

International Travel Medical Questionnaire

NAME: _____ AGE: _____ WEIGHT (approx.): _____ SEX: _____

ADDRESS: _____

CONTACT INFORMATION (telephone, e-mail): _____

ITINERARY: _____

TODAY'S DATE: _____ DEPARTURE DATE: _____

Immunizations	Yes	No	Problem*
Have you ever fainted from having your blood drawn or from an injection?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a fever reaction to vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<i>any vaccine, especially those containing tetanus-diphtheria</i>
Have you ever had a bad reaction/side effect from any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had hepatitis A or B vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder, or who is on chemotherapy for cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<i>varicella, smallpox, FluMist, MMRV, Zostavax</i>
Do you have a family history of immunodeficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<i>varicella, smallpox, MMRV, Zostavax</i>
Have you received any injection of immune globulin or any blood product during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<i>varicella, measles-containing vaccine, smallpox, MMRV, Zostavax</i>
General Medical	Yes	No	Problem*
Do you have a medical condition that warrants maintenance medications or physician follow-up?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a medical condition that is stable now, but that may recur while traveling?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have asplenia?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had an acute illness or a fever in the past 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant or might you become pregnant on this trip?	<input type="checkbox"/>	<input type="checkbox"/>	<i>MMR, oral typhoid, smallpox, varicella, MMRV, yellow fever, FluMist, HPV, Zostavax, BCG, JE, doxycycline and other antibiotics. For other vaccines weigh theoretical risk of vaccination against risk of disease.</i>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<i>smallpox, yellow fever</i>
Do you have HIV, AIDS, an AIDS-like condition, immune deficiency or other immune disorder, leukemia, or cancer, or are you taking immunomodulatory drugs, or are you post-transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<i>MMR, oral typhoid, smallpox, rabies, varicella, yellow fever, FluMist, MMRV, Zostavax, rotavirus</i>
Do you have severe combined immunodeficiency disease?	<input type="checkbox"/>	<input type="checkbox"/>	<i>rotavirus</i>
Do you have a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?	<input type="checkbox"/>	<input type="checkbox"/>	<i>yellow fever</i>
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<i>any intramuscular injection</i>
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine, DTaP, Tdap, MMRV</i>
Do you have any stomach conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<i>oral typhoid, mefloquine, doxycycline, Malarone, chloroquine, rotavirus</i>

Do you have a G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<i>chloroquine, primaquine</i>
Do you have severe renal impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Malarone</i>
Do you have a bowel condition such as diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<i>rotavirus</i>
Do you have congenital malformation of the GI tract or chronic GI disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<i>rotavirus</i>
Have you ever had hepatitis or yellow jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
Do you have a problem with strange dreams and/or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
Do you have insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
Do you have problems with vaginitis?	<input type="checkbox"/>	<input type="checkbox"/>	<i>any antibiotic</i>
Do you have psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	<i>chloroquine or related compounds</i>
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<i>smallpox</i>
Do you have cardiac disease, with or without symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<i>smallpox, FluMist</i>
Do you have any eye conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you prone to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have asthma or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	<i>FluMist</i>
Do you have multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	<i>yellow fever</i>
Medications	Yes	No	Problem*
Are you taking or will you be taking:			
quinine, quinidine, or medications for a cardiac conduction defect?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
chloroquine, mefloquine, or proguanil to prevent malaria?	<input type="checkbox"/>	<input type="checkbox"/>	
proguanil to prevent malaria?	<input type="checkbox"/>	<input type="checkbox"/>	<i>oral typhoid</i>
steroids, prednisone, or anti-cancer drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<i>MMR, oral typhoid, varicella, yellow fever, FluMist, MMRV, Zostavax</i>
antibiotics or sulfonamides?	<input type="checkbox"/>	<input type="checkbox"/>	<i>oral typhoid</i>
Pepto-Bismol® to prevent traveler's diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<i>doxycycline, tetracycline</i>
antacids?	<input type="checkbox"/>	<input type="checkbox"/>	<i>doxycycline, tetracycline</i>
oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	<i>doxycycline, tetracycline</i>
aspirin therapy? (children & adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	<i>varicella, FluMist</i>
medications for emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
medication for convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	<i>mefloquine</i>
Allergies*	Yes	No	Problem*
Are you allergic or hypersensitive to:			
any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
amphotericin B?	<input type="checkbox"/>	<input type="checkbox"/>	<i>RabAvert</i>
penicillin or sulfa?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Diamox, Fansidar, penicillin, sulfa</i>
mercury or thimerosal?	<input type="checkbox"/>	<input type="checkbox"/>	<i>See Table THIM-1 (U.S.) or Table THIM-2 (Canada).</i>
streptomycin?	<input type="checkbox"/>	<input type="checkbox"/>	<i>IPV</i>