TRAVEL CONSULT

PATIENT QUESTIONNAIRE

Please fill out this form and bring it with you to your Travel Clinic appointment.

- Bring with you any immunization records you may have.

You may have to check with previous health care providers to get all of this information.

(PLEASE PRINT)

Name:	Date of birth:	Sex: M/F

Circle any of the following that you are allergic to:

Eggs Thimerisol Sulfa Neomycin Streptomycin Bee stings

Other allergies:

Are you currently being treated for cancer? Yes/No

Do you have deficiency of the immune system? Yes/No

Do you have any **existing medical conditions,** such as diabetes, heart disease, or lung disease?

Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?
Please explain:

Have you ever had a convulsion, seizure, epilepsy, or brain infection? Yes/No

List all medications you are currently taking, either prescription or over-the-counter:

INFORMATION ABOUT YOUR TRAVEL PLAN:

Date of departure:	Length of trip:

Please indicate, in the order in which you will visit them, the countries to which you will be traveling. Also indicate length of stay in each country (bring complete details of itinerary to your appointment).

Conditions of Travel (Circle all that apply):

- Urbanized areas
- Rural areas
- Camping
- Cruise Ship
- Seashore Visit
- Guided Tour
- Rural Hiking or Bicycling
- Stay in Guest House or Hostel
- Stay in Local Home

Are you traveling: •**Alone** •**With Others:** If traveling with others that will be seen at this clinic, please provide their information below.
What is the reason for travel (pleasure, business, medical work, etc.):
Women: Are you pregnant, suspect you may be pregnant, or trying to become pregnant? Yes/No
Do you have any special concerns or questions to be answered at your appointment?

MIY 6/15