International Travel Clinic
Medical Questionnaire

Name_________________________________ **Date**______________

Date of Birth__________ **Age**_____ **Pharmacy**___________________

Phone: Home______________ **Cell**____________ **Work**_____________

Immunization Questions:	**Yes**	**No**	**Describe Problem**
1. Have you ever had a reaction or side effect from any shot?			
2. Have you ever fainted from having your blood drawn or from a shot?			
3. **FEMALE ONLY**: Are you pregnant?			
4. **FEMALE ONLY**: Are you breastfeeding?			
5. **FEMALE ONLY**: Might you become pregnant on this trip?			
6. Do you have AIDS, or have close contact with anyone with any AIDS-like condition, leukemia, or cancer?			MMR, Oral typhoid, Yellow Fever, Flumist, Rabies, Varicella, Zostavax
7. Do you have a family history of immunodeficiency?			Varicella, MMR, Zostavax
8. Have you had a fever in the past 48 hours?			
9. Have you experienced a fever after a shot? If so please list the vaccine.			Dtap, Tdap
10. Are you allergic to eggs?			Flu, Rabies, Yellow Fever, MMR
11. Do you have heart, kidney, or liver disease?			Malarone (kidney), Mefloquine, Flumist (heart)
12. Have you had your thymus gland removed or a history of thymus disease, including myasthenia gravis, DiGeorge syndrome, or thymoma?			Yellow Fever

General Medical Questions:	**Yes**	**No**	**Describe Problem**
1. Do you have skin problems?			
2. Do you have any eye conditions?			
3. Do you have any stomach conditions including GERD?			Oral Typhoid, and Travelers' Diarrhea, Mefloquine, Doxycycline, Malarone, Chloroquine

International Travel Clinic
Medical Questionnaire

4. Do you have any bowel conditions, such as diarrhea or constipation?			Travelers' Diarrhea
5. Have you had the disease hepatitis A or B or yellow jaundice?			
6. Do you have trouble sleeping?			Mefloquine
7. Do you take any medications regularly? If so please list the medication and condition that is being treated.			
8. Do you have any medical condition(s) that you see a doctor for regularly? Any past conditions?			
9. Do you have severe thrombocytopenia (low platelet count) or a blood clotting disorder?			Any intramuscular injection
10. Do you have a history of depression or other psychological/ psychiatric problems?			Mefloquine
11. Have you ever had a convulsion, seizure, or epilepsy?			Mefloquine, Dtap, Tdap
12. Are you prone to motion sickness?			
13. Who is your regular doctor?			

Medication Questions:	Yes	No	Problem
1. Are you allergic to any medications, foods or latex? If yes, **what is the reaction?**			Reaction:
2. Are you taking antibiotics?			Oral Typhoid
3. Do you take steroids, prednisone, or cortisone for any reason?			MMR, Rabies, Oral Typhoid, and Yellow Fever, Varicella, Flumist, Zostavax
4. Are you taking or will you be taking: a. Pepto-Bismol to prevent Traveler's diarrhea?			Absorption of oral medications
b. Antacids?			Same as above
c. Oral Contraceptives?			Doxycycline
5. Have you ever taken malaria medication? If so what kind? Any problems?			

International Travel Clinic
Medical Questionnaire

Allergies	Yes	No	Problem
ARE YOU ALLERGIC TO:			
• Gentamicin, streptomycin, neomycin, kanamycin			
• Sulfites			Doxycycline
• Aluminum or aluminum hydroxide			
• Mercury or thimerosal			Japanese Encephalitis, Flu (Fluzone)
• Bee stings or have history of hives or urticaria			Japanese Encephalitis
Are you hypersensitive to gelatin?			
Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formal-dehyde?			
Are you hypersensitive to soy?			Pneumococcal (PCV)
Are you hypersensitive to lactose?			Menomune, Oral typhoid

Prior Immunizations

Vaccine	Yes	No	Unknown	Date of Last Shot
Hepatitis A (2 doses)				(N/A if complete series)
Hepatitis B (3 doses)				(N/A if complete series)
Hepatits A/B combo (3 doses)				(N/A if complete series)
Influenza				
Japanese Encephalitis				
Measles, Mumps, Rubella (MMR)				
Meningococcal				
Pneumococcal				
Polio (3 doses either oral or injectable)				
Rabies				
Tetanus/Diptheria				
Tetanus/Diptheria/Pertussis				
Typhoid Injectible				
Typhoid Oral				
Yellow Fever				

International Travel Clinic
Medical Questionnaire
Trip Information

1. **Countries and cities you plan to visit (please list in sequence):**

City &Country	Arrival date	Departure date	Urban	Rural	How Long?

2. **Where will you be staying? (Please circle all that apply)**

Major resort hotels
Staying with family or friends
Renting home/apt./condo
Small Hotels
Camping
Cruise ship
Hostel
Other:____________________

3. **What is the purpose or type of activities you will be doing during your trip? (Please circle all that apply):**

Vacation
Business
Relocation to the country
Visiting Friends and Family
Outdoor activities
Safari
Missionary
Student
Volunteer Agency
Adoption

Will you be:
Driving a car
Scuba diving
Mountain Climbing
Bicycling
Hiking

Other____

4. **Who is traveling with you?**

Spouse
Family Member(s)
Friend
Tour group
Church Group

Children (list age) __________________________
____
____
____

How did you hear about our travel services?

____

____

☐ I have received the FWC International Travel Clinic HIPAA policy________