

## International Travel Medicine Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Weight (approx): \_\_\_\_\_ Sex: \_\_\_\_\_

Itinerary: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Departure: \_\_\_\_\_

Immunizations	Yes	No	Problems
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"/>	DPT, Td, Wyeth Injectable Typhoid
Have you ever had any bad reaction or side effect from any vacation?	<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"/>	OPV, Varicella
Do you have a family history of immunodeficiency?	<input type="checkbox"/>	<input type="checkbox"/>	OPV, Varicella
Have you received any injection of immune globulin or any blood product during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Varicella, Measles containing vaccine

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"/>	
Have you had a fever in the past 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Cholera, DTP, Td, Influenza, Meningococcal, Oral typhoid, Pneumococcal (Polysaccharide)
Are you pregnant or might you become pregnant on this trip?	<input type="checkbox"/>	<input type="checkbox"/>	MMR or components, OPV, Oral typhoid, Varicella, Yellow fever (for other immunizations weigh the theoretical risk of vaccination against the risk of disease), Doxycycline and other antibiotics
Do you have AIDS, an AIDS like condition, any other immune disorder, leukemia or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	MMR or components, OPV, Oral typhoid, Rabies, Varicella, Yellow fever
Do you have severe thrombocytopenia (low platelet count) or coagulation disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Any intramuscular injection
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine, DTaP, DTP
Do you have stomach conditions?	<input type="checkbox"/>	<input type="checkbox"/>	OPV, Oral typhoid, Mefloquine
Do you have a G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	Chloroquine, Primaquine
Do you have bowed conditions such as diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had hepatitis or yellow fever?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C
Do you have a history of psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
Do you have a problem with strange dreams and/or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
Do you have insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
Do you have problems with vaginitis?	<input type="checkbox"/>	<input type="checkbox"/>	Any antibiotic
Do you have psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Chloroquine or related compounds
Do you have any eye conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you prone to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>	