SafeTreks™ Travel Medicine

Isn't it time you went somewhere?

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International Society of Travel Medicine

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# Travel Health Questionnaire

**Name:** _____ **DOB:** _____
Last First Middle

**Email:** _____ **Phone:** _____

**Travel Itinerary, Travel Destination, & Travel Dates:**

_____

_____

_____

_____

_____

**Do your travel plans include any of the following activities?**

Hiking / Trekking **Y / N**
Camping **Y / N**
Swimming **Y / N**
Boating / Yachting / Cruising **Y / N**
Scuba Diving **Y / N**
High Altitude Destinations **Y / N**

Potential Sexual Contacts **Y / N**
Piercing/Tattooing **Y / N**
Rural Destinations **Y / N**
Farm or Safari Destinations **Y / N**
Contact with animals **Y / N**
Visiting Friends & Relatives **Y / N**

**Have you ever experienced any of the following travel-related conditions?**

High Altitude Illness **Y / N**
Travelers' Diarrhea **Y / N**
Travel-Related Edema **Y / N**
Travel-Related Insomnia **Y / N**

Other Travel-Related Illness? **Y / N**
Please list:_____
_____
_____

**Have you ever experienced any of the following travel-related conditions?**

Asthma **Y / N**
Arthritis **Y / N**
Blood Clots **Y / N**
Cancer **Y / N**
Chronic Lung Disease **Y / N**
Coumadin Therapy **Y / N**
Depression / Anxiety **Y / N**
Diabetes **Y / N**
Edema **Y / N**
Heart Disease **Y / N**
HIV/AIDS **Y / N**
Immune Suppression **Y / N**
Musculoskeletal Injuries **Y / N**
Thymus Disorder **Y / N**
Tuberculosis **Y / N**

**Please list all your medical conditions:**

_____

_____

_____

_____

_____

**Please list all your medications, including over the counter medications, vitamins, supplements and herbs:**

_____

_____

_____

_____

_____

**Do you take medications that suppress your immune system such as prednisone, chemotherapy drugs, or drugs for rheumatoid arthritis and other autoimmune diseases? Y / N**

**Are you pregnant or planning to become pregnant while traveling? Y / N**

**Are you breast-feeding? Y / N**

**Are you ALLERGIC to any medications?**

**If yes, please list:** _____

_____

_____

**Are you ALLERGIC to:**

Eggs **Y / N**
Yeast **Y / N**
Thimerosal **Y / N**
Latex **Y / N**
Mercury **Y / N**
Vaccines **Y / N**

**If you have a Vaccination Record, please forward or bring a copy.**

**Have you received any vaccinations in the last 4 weeks?** **Y / N**

**Are you allergic to any vaccines?** **Y / N**

**Have you received any of the following vaccines, if so when?**

| | | **Dates:** |
|---|---|---|
| Chicken pox | **Y / N** | _____ |
| Hepatitis A | **Y / N** | _____ |
| Hepatitis B | **Y / N** | _____ |
| Human Papillomavirus (HPV) | **Y / N** | _____ |
| Influenza | **Y / N** | _____ |
| Japanese Encephalitis | **Y / N** | _____ |
| Measles, mumps, rubella | **Y / N** | _____ |
| Meningococcal | **Y / N** | _____ |
| Pneumococcal | **Y / N** | _____ |
| Polio | **Y / N** | _____ |
| Rabies | **Y / N** | _____ |
| Shingles | **Y / N** | _____ |
| Tetanus & Diptheria | **Y / N** | _____ |
| Tetanus, Diptheria & Pertussis | **Y / N** | _____ |
| Typhoid | **Y / N** | _____ |
| Yellow Fever | **Y / N** | _____ |

**Signed:** _____ **Date:** _____