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:** _____