International Travel Medical Questionnaire

Name: ____Age: _____ Sex: _____

List all countries you will visit:

____

Departure date: ___________________________ Return date: ___________________________

Reason for travel (i.e. business, pleasure): ____

Are you visiting an urban or rural area? ____

Lodging (hotel, hostel, friends, family) ____

Women – First day of your last period: ____

Immunizations	**Yes**	**No**
Have you received any shots (vaccinations) in the past 4 weeks?	◻	◻
Have you ever fainted from having your blood drawn or from an injection?	◻	◻
Have you ever had a fever after a vaccine?	◻	◻
Have you had *any* bad reaction or side effect from a vaccine?	◻	◻
Have you ever received Hepatitis A or B vaccine?	◻	◻
Do you live (or work closely with anyone who has AIDS, or any other immune disorder, or who is on chemotherapy for cancer or family history of immune disorders?	◻	◻
Have you received immune globulin or any blood product during the past 12 months?	◻	◻
General Medical	**Yes**	**No**
Do you have a condition that requires medicines or doctor follow-up?	◻	◻
Do you have a condition that is stable now, but that may return while traveling?	◻	◻
Has your spleen been removed?	◻	◻
Have you had an illness or a fever in the past 48 hours?	◻	◻
Are you pregnant or might you become pregnant on this trip?	◻	◻
Are you breastfeeding?	◻	◻
Do you have HIV, AIDS, other immune disorder, leukemia, or cancer?	◻	◻
Do you have a severe, combined immune disorder?	◻	◻
Have you had your thymus gland removed or history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome or thymoma?	◻	◻
Do you have severe low platelet count or blood clotting disorder?	◻	◻
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	◻	◻
Do you have any stomach conditions?	◻	◻
Do you have a G6PD deficiency?	◻	◻
Do you have severe kidney (renal) damage?	◻	◻

Do you have a history of mental problems?	□	□
Do you have a problem with strange dreams or nightmares?	□	□
Do you have insomnia?	□	□
Do you have problems with vaginitis?	□	□
Do you have psoriasis?	□	□
Do you get motion sickness?	□	□
Have you ever had headaches, nausea, vomiting or breathing problems from high altitudes?	□	□
Medicines	**Yes**	**No**
Are you taking:		
Steroids, prednisone, or anti-cancer drugs?	□	□
Antibiotics or sulfonamides?	□	□
Oral contraceptives?	□	□
Aspirin therapy? (children and teens)	□	□
Allergies	**Yes**	**No**
Are you allergic to:		
Any medicines?	□	□
Any foods or other?	□	□

NOTE: Some of the questions listed above may lead to a discussion with your care team about the risks/benefits of a particular vaccine.

If you have a medical condition that is not treated through the Fairview Health Services, please complete the following:

Medical history:

Surgical history:

Current medicines:

Signature: ______________________________ *Date:*________ *Time:* ________