Pre-Travel Health Consultation and Health Form

Traveler: _____ Home Phone: _____
Date of Birth: _____ Work Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____
_____ Sex: M F Citizenship: _____
Date Form Completed: _____ Country of Birth: _____
Physician: _____ Form Completed by: _____

Trip Information

Itinerary: Please give ALL countries & cities to be visited, including stopovers, in order to be visited and time planned to spend in each place. Attach Itinerary if available. (Add sheet if needed)_____

Date of Departure from Home: _____
Return date/Length of Trip: _____
Have you traveled internationally in the past? Y N
Where: _____

Do you intend to travel frequently in future? Y N Maybe

Destination: ☐ Urban ☐ Rural ☐ Remote ☐ High Altitude ☐ Beach

Purpose of Trip: *(Check all that apply):*

☐ Medical Care ☐ Business ☐ Long-Stay Traveler ☐ Volunteer/Humanitarian
☐ Adoption ☐ Education ☐ Vacation ☐ Visiting Friends/Relatives

Organized Tour: Y N Partly Details: _____

Accommodations: ☐ Hotel ☐ Camping ☐ Rented House/Apt
☐ Hostel ☐ Cruise/Boat ☐ Staying with Locals/Family/Friend

Will You Be Traveling Alone? Y N Who are you traveling with? _____

Planned Activities: *(Check all that apply)*

☐ Air Travel ☐ Biking ☐ Hiking ☐ Snorkeling ☐ Swimming ☐ Rafting ☐ Boating ☐ Scuba
☐ Climbing/Trekking ☐ Contact with Animals ☐ Cave/Spelunking ☐ Public Transportation (Bus, Train)
☐ Visiting schools, hospitals or orphanages ☐ Health Care Worker ☐ Occupational Exposure

Have you obtained travel medical evacuation insurance? Y N From: _____

Health History

Heath Care Provider: _____ Telephone: _____

Address: _____

Do you have any chronic health problems for which you take medication on a regular basis or see a health care provider? Y N If Yes, please explain: _____

Are you currently under the care of a physician for any health problem: Y N If Yes, please explain: _____

Health History Continued:

Do you currently have or have a past history of:

Antidepressant or psychiatric medication use	☐ Yes ☐ No
Depression, anxiety, panic attacks	☐ Yes ☐ No
Psoriasis (skin disease)	☐ Yes ☐ No
Seizures or convulsions	☐ Yes ☐ No
Cardiac conduction defect, have a pacemaker	☐ Yes ☐ No
Heart disease or surgery	☐ Yes ☐ No
Respiratory (lung)disease	☐ Yes ☐ No
Muscle or bone problems	☐ Yes ☐ No
Intestinal problems includidng heartburn or reflux	☐ Yes ☐ No
Immune disorder (chemo, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment)	☐ Yes ☐ No
Live/work closely with anone with immune disorder	☐ Yes ☐ No
Thymus gland surgery or disorder (myasthenia gravis, DiGeorge Syndrome)	☐ Yes ☐ No
History of altitude Illness	☐ Yes ☐ No
Surgery or hospitalization in the past 3-5 years	☐ Yes ☐ No
Have you had any transfusions or blood products int he past 5 years?	☐ Yes ☐ No
Have you ever had Hepatitis (liver infection)?	☐ Yes ☐ No
Has your spleen been removed?	☐ Yes ☐ No
Do you drink alcohol regularly?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No
Have you ever had a TB test?	☐ Yes ☐ No
History of tendonitis/Achille's heel rupture	☐ Yes ☐ No
Other medical problems?	☐ Yes ☐ No

Please explain any YES answers: (use additional sheet if necessary) _____

_____

_____

_____

Women ONLY:

Last Menstrual period? _____ Was it normal? ☐ Yes ☐ No

Any risk of an unplanned pregnancy? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

What form of contraception do you use? _____

Allergies

Medications ☐ Yes ☐ No If Yes explain: _____

Reaction to Vaccine: ☐ Yes ☐ No If Yes explain: _____

Egg or other food allergies ☐ Yes ☐ No If Yes explain: _____

Environmental (pollen,dust, hay fever, etc.) ☐ Yes ☐ No If Yes explain: _____

Animals ☐ Yes ☐ No If Yes explain: _____

Bee Stings ☐ Yes ☐ No If Yes explain: _____

Have you ever experienced anaphylaxis (severe allergic reaction)? ☐ Yes ☐ No

Medications:

Please list **ALL** prescribed and over-the-counter medications and supplements you use or considering using for this trip:

Medication:	Reason for Use:	Medication:	Reason for Use:
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

When was your last dental visit? _____

Please tell us any additional information that you believe is important for us to know as you prepare for your current trip:

_____

_____

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature: _____ **Relationship if minor** _____

Reviewed by: _____ RN/NP/PA/MD

THE CENTER FOR PEDIATRICS TRAVEL DESTINATION INQUIRY FORM

Please provide information on your exact trip itinerary below:

Date of Departure from United States: _____

Airport of Departure from U.S.:_____

Will you be connecting to another airport before arriving at your final travel destination? ____YES_____NO

If YES, please give information on below:

Connecting airport name:_____/CITY:_____/COUNTRY:_____

If no, please state your final arrival destination airport name:_____CITY_____COUNTRY:_____

Date of ARRIVAL to your final destination:_____

WHERE IS YOUR FINAL DESTINATION? (CITY and COUNTRY)_____

Will you be traveling to other cities or towns in that same country? IF YES, please list in ORDER of visitation, the exact cities and towns you plan to travel in within that country and how long you will be in each town (days vs. weeks):

_____

_____

_____

_____

ARE YOU PLANNING on traveling to other countries? If so, list below any further airports traveling to and the CITIES as well as COUNTRIES you will be traveling to. LIST ALL CITIES AND COUNTRIES please IN ORDER OF TRAVEL.

_____

Please state what airport you are departing from to return back to USA and if you will be having any connection flights, and if so where (city, country). THANK YOU!

_____

_____

_____

Thank you, Kristen Baker, PA-c

International Travel Medical Questionnaire

NAME:_____ AGE:_____ WEIGHT (approx.):_____ SEX:_____

ITINERARY: _____

DATE: _____ DATE OF DEPARTURE:_____

Immunizations	Yes	No	Problem*
Have you ever fainted from having your blood drawn or from an injection?	☐	☐	
Have you ever had a fever reaction to vaccination?	☐	☐	*any vaccine, especially those containing tetanus-diphtheria*
Any bad reaction/side effect from any vaccination?	☐	☐	
Have you ever had hepatitis A or B vaccine?	☐	☐	
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?	☐	☐	*varicella, smallpox, FluMist, influenza, H1N1 (intranasal), MMRV, Zostavax*
Do you have a family history of immunodeficiency?	☐	☐	*varicella, smallpox, MMRV, Zostavax*
Have you received any injection of immune globulin or any blood product during the past 12 months?	☐	☐	*varicella, measles-containing vaccine, smallpox, MMRV, Zostavax*
General Medical	**Yes**	**No**	**Problem***
Do you have a medical condition that warrants maintenance medications or physician follow-up?	☐	☐	
Do you have a medical condition that is stable now, but that may recur while traveling?	☐	☐	
Do you have asplenia?	☐	☐	
Have you had an acute illness or a fever in the past 48 hours?	☐	☐	
Are you pregnant or might you become pregnant on this trip?	☐	☐	*MMR, oral typhoid, smallpox, varicella, MMRV, yellow fever, FluMist, influenza H1N1 (intranasal), HPV, Zostavax, BCG, JE, doxycycline and other antibiotics. For other vaccines weigh theoretical risk of vaccination against risk of disease.*
Are you breast feeding?	☐	☐	*smallpox, yellow fever*
Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	☐	☐	*MMR, oral typhoid, smallpox, rabies, varicella, yellow fever, FluMist, influenza H1N1 (intranasal), MMRV, Zostavax, rotavirus*
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?	☐	☐	*yellow fever*
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	☐	☐	*any intramuscular injection*
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	☐	☐	*mefloquine, DTaP, Tdap, MMRV*
Do you have any stomach conditions?	☐	☐	*oral typhoid, mefloquine, doxycycline, Malarone, chloroquine, rotavirus*
Do you have a G6PD deficiency?	☐	☐	*chloroquine, primaquine*
Do you have severe renal impairment?	☐	☐	*Malarone*
Bowel condition such as diarrhea or constipation?	☐	☐	*rotavirus*

Do you have congenital malformation of the GI tract or chronic GI disorder?	☐	☐	*rotavirus*
Have you ever had hepatitis or yellow jaundice?	☐	☐	
Do you have a history of psychiatric problems?	☐	☐	*mefloquine*
Do you have a problem with strange dreams and/ or nightmares?	☐	☐	*mefloquine*
Do you have insomnia?	☐	☐	*mefloquine*
Do you have problems with vaginitis?	☐	☐	*any antibiotic*
Do you have psoriasis?	☐	☐	*chloroquine or related compounds*
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis?	☐	☐	*smallpox*
Do you have cardiac disease, with or without symptoms?	☐	☐	*smallpox, FluMist*
Do you have any eye conditions?	☐	☐	
Are you prone to motion sickness?	☐	☐	
Do you have asthma or wheezing?	☐	☐	*influenza H1N1 (intranasal)*
Medications	**Yes**	**No**	**Problem***
ARE YOU TAKING OR WILL YOU BE TAKING:			
• quinine, quinidine, or medications for a cardiac conduction defect?	☐	☐	*mefloquine*
• chloroquine, mefloquine, or proguanil to prevent malaria?	☐	☐	
• proguanil to prevent malaria?	☐	☐	*oral typhoid*
• steroids, prednisone, or anti-cancer drugs?	☐	☐	*MMR, oral typhoid, varicella, yellow fever, FluMist, influenza H1N1 (intranasal), MMRV, Zostavax*
• antibiotics or sulfonamides?	☐	☐	*oral typhoid*
• Pepto-Bismol® to prevent traveler's diarrhea?	☐	☐	*doxycycline, tetracycline*
• antacids?	☐	☐	*doxycycline, tetracycline*
• oral contraceptives?	☐	☐	*doxycycline, tetracycline*
• aspirin therapy? (children & adolescents)	☐	☐	*varicella, FluMist, influenza H1N1 (intranasal)*
• medications for emotional problems?	☐	☐	*mefloquine*
• medication for convulsions?	☐	☐	*mefloquine*
Allergies†	**Yes**	**No**	**Problem***
ARE YOU ALLERGIC TO:			
• *any* medications?	☐	☐	
• amphotericin B?	☐	☐	*rabies (PCEC)*
• penicillin or sulfa?	☐	☐	*Diamox, Fansidar, penicillin, sulfa*
• mercury or thimerosal?	☐	☐	*See Table THIM-1.*
• streptomycin?	☐	☐	*IPV*
• gentamicin?	☐	☐	*FluMist, Fluarix, influenza H1N1 (intranasal)*

• neomycin?	☐	☐	*Hep A (Havrix), Hep A/B, influenza (Afluria, Fluviron, Agriflu), IPV, MMR, rabies, varicella, Zostavax, MMRV, Pediarix, smallpox, Kinrix, Pentacel, influenza H1N1 (CSL, Novartis)*
• polymyxin?	☐	☐	*influenza (Fluvirin, Afluria), IPV, Pediarix, smallpox, Kinrix, Pentacel, influenza H1N1 (CSL, Novartis)*
• kanamycin?	☐	☐	*Agriflu*
• sulfites?	☐	☐	*doxycycline*
• protamine sulfate?	☐	☐	*Ixiaro*
• aluminum or aluminum hydroxide?	☐	☐	*Hep A, Hep B, Hep A/B, Comvax, DTaP, Td, rabies (RVA), anthrax, PCV, Tdap, TBE, HPV, Kinrix, Pentacel, Ixiaro*
• benzethonium chloride?	☐	☐	*anthrax*
• 2-phenoxyethanol?	☐	☐	*Hep A (Havrix), Hep A/B, IPV, DTaP (Infnarix, Pediarix), Tdap (Adacel), Pentacel*
• bee stings or history of hives or urticaria?	☐	☐	*JE-VAX*
• yeast?	☐	☐	*Hep B, Hep A/B, Pediarix, Comvax, PCV, oral typhoid, Gardasil*
• eggs, ovalbumin, or chicken protein?	☐	☐	*influenza (seasonal), rabies (PCEC), yellow fever, MMR, MMRV, TBE, influenza (H1N1)*
• chlortetracycline?	☐	☐	*rabies (PCEC)*
• latex?	☐	☐	*Consult package insert.*
• Are you hypersensitive to gelatin?	☐	☐	*varicella, JE-VAX, MMR, DTaP, yellow fever, rabies (PCEC), influenza (Fluzone, FluMist), oral typhoid, MMRV, Zostavax, influenza H1N1 (intranasal)*
• Are you hypersensitive to soy?	☐	☐	*PCV*
• Are you hypersensitive to lactose?	☐	☐	*Menomune, oral typhoid, Hiberix*

* Note: *Any "problem" listed above may be a contraindication or merely a precaution that warrants further discussion between the health care provider and patient. The "problem" list is not all-inclusive but is representative of common issues that arise in a pre-travel consultation.*

† Not all-inclusive. Check package inserts and also see CDC "Pink Book" (Appendix B for a complete list of vaccine excipients.

BASED ON: Manufacturer package inserts; CDC: *Epidemiology and Prevention of Vaccine-Preventable Diseases*, 11th edition, Appendix B, 2009.