INTERNATIONAL TRAVEL MEDICINE QUESTIONNAIRE

NAME: _____ AGE: _____ WEIGHT (APPROX): _____ SEX: _____

ITINERARY (in order, including duration of stay): _____

_____

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?	❑	❑	*(DTP, Td, Wyeth Injectable Typhoid)*
Have you ever had *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?	❑	❑	*(OPV, Varicella)*
Do you have a family history of immunodeficiency?	❑	❑	*(OPV, Varicella)*

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 may occur while traveling?	❑	❑	
Have you had a fever in the past 48 hours?	❑	❑	*(Cholera, DTP, Td, Influenza, Meningococcal, Oral typhoid, Pneumococcal)*
Are you pregnant* or might you become pregnant on this trip?	❑	❑	*(MMR or components, OPV, Oral typhoid, Varicella, Yellow fever, most other immunizations in the first trimester, Doxycycline and other antibiotics)*
Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia or cancer?	❑	❑	*(MMR or components, OPV, Oral typhoid, Rabies, Varicella, Yellow fever)*
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	❑	❑	*(any intramuscular injection)*
Have you ever had a convulsion, seizure or epilepsy?	❑	❑	*(Mefloquine, Pertussis)*
Do you have any stomach conditions?	❑	❑	*(OPV, Oral typhoid, Mefloquine)*
Do you have bowel conditions such as diarrhea or constipation?	❑	❑	
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?	❑	❑	
Do you have problems with vaginitis?	❑	❑	*(any antibiotic)*
Do you have psoriasis?	❑	❑	*(Chloroquine or related compounds)*
Do you have any eye conditions?	❑	❑	
Are you prone to motion sickness?	❑	❑	

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685 Palm Springs Dr., Suite 2A, Altamonte Springs, FL 32701 • (407) 830-5577 • FAX (407) 830-4164

MEDICATIONS ARE YOU TAKING OR WILL YOU BE TAKING:	YES	NO	PROBLEM*
◦ quinine, quinidine or medications or a cardiac conduction defect?	❑	❑	*(Mefloquine)*
◦ chloroquine or mefloquine to prevent malaria?	❑	❑	*(Oral typhoid, Rabies, [HDCV ID])*
◦ steroids, prednisone or cortisone?	❑	❑	*(MMR or components, OPV, Oral typhoid, Rabies, Varicella, Yellow fever)*
◦ antibiotics?	❑	❑	*(Oral typhoid)*
◦ Pepto-Bismol to prevent travelers' diarrhea?	❑	❑	*(Doxycycline, tetracycline)*
◦ antacids?	❑	❑	*(Doxycycline, tetracycline)*
◦ oral contraceptives?	❑	❑	*(Doxycycline, tetracycline)*
◦ aspirin therapy? (children & adolescents)	❑	❑	*(Varicella)*
◦ medications for emotional problems?	❑	❑	*(Mefloquine)*

ALLERGIES ARE YOU allergic to:	YES	NO	PROBLEM*
◦ any medications?	❑	❑	
◦ penicillin or sulfa?	❑	❑	*(Diamox®, Fansidar®, Penicillin, Sulfa)*
◦ mercury or thimerosal?	❑	❑	*(DTP, DTaP, DT, Td, Hib, Japanese encephalitis, Hepatitis B, IG, Influenza, Meningococcal, Pneumococcal [PNU-IMUNE®23], Rabies [RVA;HRIG])*
◦ gentamicin?	❑	❑	*(Influenza [FluShield™])*
◦ neomycin?	❑	❑	*(Influenza [Fluvirin™], IPV, MMR or components, Rabies [HDCV], Varicella)*
◦ polymyxin?	❑	❑	*(Influenza [Fluvirin™], IPV)*
◦ streptomycin?	❑	❑	*(Influenza [Fluogen®], IPV)*
◦ sulfites?	❑	❑	*(Influenza [Fluogen®], Plague)*
◦ aluminum or aluminum hydroxide?	❑	❑	*(Hepatitis A, COMVAX™, PedvaxHIB®, DTap, DTP, Td, Rabies [RVA])*
◦ 2-phenoxyethanol?	❑	❑	*(Hepatitis A [Havrix®], IPV, DTaP [Infantrix™])*
◦ bee stings, or have history of hives or urticaria?	❑	❑	*(Japanese encephalitis)*
◦ yeast?	❑	❑	*(Hepatitis B, Plague)*
◦ eggs?	❑	❑	*(Influenza, MMR or components, Yellow fever)*
◦ are you hypersensitive to gelatin?	❑	❑	*(Varicella, Japanese encephalitis, MMR or components, DTaP)*
◦ are you hypersensitive to beef protein, soy, casein, lactose, phenol or formaldehyde?	❑	❑	*(Plague, PedvaxHIB® (lyophilized), TETRAMUNE™, IPV, Meningococcal, Oral typhoid and Typhoid USP, all Rabies vaccines, DTaP, DTP)*

◦ *NOTE: A "problem" listed in parentheses may be a contraindication or merely a precaution that warrants further discussion between health care provider and patient. The problems listed are not all-inclusive: for example, during pregnancy, risks and benefits of most immunizations should be weighed, although pregnancy is not a contraindication to hepatitis B immunization.*

COMMENTS: _____

SIGNATURES: _____ (Traveler) _____ (Health Care Provider)

DATE: _____

IDC TRAVEL HEALTH

PRE-APPOINTMENT SCREENING

☐ CR ☐ JC ☐ ED ☐ TC ☐ FA ☐ JS ☐ CC ☐ VH ☐ RO

TODAY'S DATE: _____ PATIENT NAME: _____

APP'T DATE: _____ APP'T SCREENING DONE BY: _____

DOB: _____ TELEPHONE #: _____ REFERRED BY: _____

DEPARTURE DATE: _____ RETURN DATE: _____

APPROXIMATE LENGTH OF TRIP: _____WEEKS _____MONTHS _____ YEAR(S)

TRAVEL METHOD: ☐ AIR ☐ CRUISE ☐ BACKPACKER ☐ OTHER _____

PURPOSE OF TRAVEL: ☐ TOURISM ☐ BUSINESS ☐ EDUCATION ☐ OTHER _____

ACCOMODATIONS: ☐ HOTEL ☐ RESORT ☐ CAMPING ☐ FRIEND ☐ MILITARY BASE

☐ OTHER _____

ITINERARY

CITY & COUNTRY: _____ RURAL ☐ URBAN ☐ DON'T KNOW ☐

_____ RURAL ☐ URBAN ☐ DON'T KNOW ☐

_____ RURAL ☐ URBAN ☐ DON'T KNOW ☐

_____ RURAL ☐ URBAN ☐ DON'T KNOW ☐

PRIOR IMMUNIZATIONS (INCLUDE APPROX. DATES)

TRAVEL RELATED

_____Yellow Fever
_____Typhoid Fever
_____Hepatitis A (Doses _____)
_____Hepatitis B (Doses _____)
_____Tetanus or Td
_____Japanese Encephalitis
_____Cholera
_____Plague

ROUTINE (In Childhood)

_____MMR (Measles- Mumps-Rubella)
_____Diphtheria-Tetanus-Pertussis (DPT)
_____Pneumococcal
_____Polio (IVP) Injected
_____Polio (OPV) Oral
_____Varicella (Chickenpox)
_____Influenza
_____Diphtheria-Tetanus-Pertussis (DPT)

OTHER:

_____Meningococcal (Doses _____)
_____Rabies
_____Immunoglobulin (IM)
_____
_____
_____
_____
_____

Allergy to drugs or vaccines: ☐ No ☐ Yes: (Explain) _____

Allergy to Eggs: ☐ No ☐ Yes: (Explain) _____

PLEASE BRING YOUR IMMUNIZATION RECORDS TO APPOINTMENT

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IMMUNIZATION- VACCINATION CONSENT

I have been informed of the benefits and risks of the following immunizations and/or vaccines:

_____

_____

_____

_____

_____

_____

I have had the opportunity to ask questions and I request that the above immunizations and/or vaccinations be administered to me, or the person named below for whom I am authorized to sign.

Information concerning the client to receive vaccinations:

_____ _____

Name Age

_____

Address City State Zip Code

_____ _____

Signature of client or authorized representative Relationship to authorized representative

_____

Date

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