

Travel Screening Questionnaire

Exact Name on Passport _____ Date of Birth _____ Today's Date _____

Travel Information

1. Departure Date: _____ Return Date: _____

2. Destinations (in order of visit): Please attach a separate list if needed.

Country and City or Location	Arrive	Depart	Urban/Rural? / Activities? / Lodging Type?

3. Circle reason for travel: Mission / Vacation / Business / Education / Medical / Other _____

4. List all allergies and sensitivities, especially medications: If none, please indicate by checking the box below. _____

No allergies and/or sensitivities:

5. Have you had any reaction or side effect from any vaccination? Check here if **none**:

If **yes**, please explain: _____

6. Medications: Please list all the medications you are currently taking, including over the counter medications, vitamins and minerals, and herbal supplements. You may attach a separate list if needed.

Name of Medication/Dosage	Name of Medication/Dosage	Name of Medication/Dosage

7. Medical History

Have you ever fainted from having blood drawn or from an injection? Yes No

Do you live (or work closely) with anyone who has a deficiency of the immune system? Yes No

Do you have any deficiency of the immune system, or are you taking steroids or chemotherapy? Yes No

Have you had a blood transfusion or Immune globulin in the past 6 months? Yes No

Have you had any surgical procedure in the past 6 months? Yes No

Do you have a medical condition followed by a physician? Yes No

If **yes**, please list: _____

8. Have you had or do you currently have any of the following:

<input type="checkbox"/> Fever in the past 48 hours?	<input type="checkbox"/> High Blood Pressure?	<input type="checkbox"/> Heart Disease (irregular heartbeat)?
<input type="checkbox"/> Diabetes?	<input type="checkbox"/> Convulsions, seizures, epilepsy?	<input type="checkbox"/> Psoriasis?
<input type="checkbox"/> Low platelet count/coag. disorder?	<input type="checkbox"/> Hepatitis, jaundice, liver disease?	<input type="checkbox"/> Rheumatoid Arthritis?
<input type="checkbox"/> Stomach/bowel problems?	<input type="checkbox"/> Eye disease/condition?	<input type="checkbox"/> Tuberculosis/lung disease?
<input type="checkbox"/> Folic acid deficiency?	<input type="checkbox"/> Depression, anxiety, psychiatric problems?	<input type="checkbox"/> Kidney disease?
<input type="checkbox"/> Cancer, chemo, radiation therapy?	<input type="checkbox"/> Asthma?	<input type="checkbox"/> Insomnia, nightmares?

9. Check any of the diseases you have had: Chicken Pox Mumps Measles Rubella (German Measles)

10. Women Only: Are you pregnant? Yes No Planning to become pregnant within the next year? Yes No

Using birth control measures? Yes No Breastfeeding? Yes No

******PLEASE BRING DOCUMENTATION OF ALL VACCINATIONS TO YOUR APPOINTMENT******

Signature _____ Date _____