Travel Screening Questionnaire

Exact Name on Passport _____ Date of Birth _____ Consultation Date _____

(*Clients 18 and under – Height self-reported ____ ft ____ in / Weight self-reported - _____ lbs.***)**

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 of 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:

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