



International Travel Patient Questionnaire

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Preferred Phone: _____ Work Phone: _____

Weight (if under 100 lbs): _____ Sex: M F

Pregnant : Y N Breast feeding: Y N Planning to become pregnant: Y N

Heart, Kidney or liver problems: Y N Allergic to eggs: Y N Allergic to Thimerosal: Y N

Recent Trave: _____

Current Meds: _____

All countries you will visit in order, first to last: _____

Do you expect to come in contact with animals: _____

Date of Departure: _____ Length of trip: _____

Purpose: _____ Urban: _____ Rural: _____ Both: _____

This box is for clinic use only

Plan:

Pharmacy # _____ RX Chloroquine 500 mg# _____

Teaching Checklist

Mefloquine 250mg# _____

General info: _____ Malaria Rx _____ Mararone 250/100mg# _____

_____ Tdap _____ Td _____ Polio _____ MMR Doxycycline 100mg# _____

_____ Meningococcal Meningitis _____ Yellow Fever _____ Hepatitis _____ A _____ B

_____ J.Enceph. _____ Typhoid (inj) _____ Oral Typhoid _____ Imm. Globulin _____ Flu _____ VZV

Work -Up prepared By: _____