**International Travel Medical Questionnaire**

### Immunizations

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Problem*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever fainted from having your blood drawn or from an injection?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a fever reaction to vaccination?</td>
<td>☐</td>
<td>☐</td>
<td>DTaP, Td, Tdap</td>
</tr>
<tr>
<td>Any bad reaction/side effect from any vaccination?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you ever had hepatitis A or B vaccine?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>☐</td>
<td>☐</td>
<td>Varicella, Smallpox, Influenza (FluMist®) MMRV, Zoster Vaccine Live (Zostavax®)</td>
</tr>
<tr>
<td>Do you have a family history of immunodeficiency?</td>
<td>☐</td>
<td>☐</td>
<td>Varicella, Smallpox, MMRV, Zoster Vaccine Live (Zostavax®)</td>
</tr>
<tr>
<td>Have you received any injection of immune globulin or any blood product during the past 12 months?</td>
<td>☐</td>
<td>☐</td>
<td>Varicella, Measles-containing vaccine, Smallpox, MMRV, Zoster Vaccine Live (Zostavax®)</td>
</tr>
</tbody>
</table>

### General Medical

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Problem*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a medical condition that warrants maintenance medications or physician follow-up?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you have a medical condition that is stable now, but that may recur while traveling?</td>
<td>☐</td>
<td>☐</td>
<td>Td, Influenza, Meningococcal, Oral Typhoid, pneumococcal, (PPV), Tdap, MMRV</td>
</tr>
<tr>
<td>Have you had a fever in the past 48 hours?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are you pregnant* or might you become pregnant on this trip?</td>
<td>☐</td>
<td>☐</td>
<td>MMR or components, Oral typhoid, Smallpox, Varicella, MMRV, Yellow Fever, Influenza (FluMist®), HPV (Gardasil®), Zoster Vaccine Live (Zostavax®), Doxycycline and other antibiotics. For other immunizations weigh the theoretical risk of vaccination against the risk of disease.</td>
</tr>
</tbody>
</table>
Do you have AIDS or an AIDS-like condition, any other immune disorder, leukemia, or cancer?

Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?

Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?

Have you ever had a convulsion, seizure, epilepsy, neurologic condition or brain infection?

Do you have any stomach conditions?

Do you have a G6PD deficiency?

Do you have severe renal impairment?

Bowel condition such as diarrhea or constipation?

Have you ever had hepatitis or yellow jaundice?

Do you have a history of psychiatric problems?

Do you have a problem with strange dreams and/or nightmares?

Do you have insomnia?

Do you have problems with vaginitis?

Do you have psoriasis?

Have you or a member or your household ever been diagnosed with eczema or atopic dermatitis (e.g., itchy, red, scaly rash lasting >2 weeks that often comes and goes)?

Cardiac disease, with or without symptoms?

Do you have any eye conditions?

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**Medications**

<table>
<thead>
<tr>
<th>ARE YOU TAKING OR WILL YOU BE TAKING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUININE, QUINIDINE, OR MEDICATIONS FOR A CARDIOVASCULAR DEFECT?</td>
</tr>
<tr>
<td>CHLOROQUINE, MEfloquine, OR PROGUANIL TO PREVENT MALARIA?</td>
</tr>
<tr>
<td>PROGUANIL TO PREVENT MALARIA?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Problem*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mefloquine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mefloquine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral typhoid</td>
</tr>
</tbody>
</table>

**MMR or components, Oral typhoid, Smallpox, Rabies, Varicella, Yellow fever, influenza (FluMist®), MMRV, Zoster Vaccine Live (Zostavax®)**

Yellow Fever

Any intramuscular injection

Mefloquine, DTaP, MMRV

Oral typhoid, Mefloquine, Doxycycline

Chloroquine, Primaquine

Malarone

Rotavirus

Mefloquine

Mefloquine

Mefloquine

Any antibiotic

Chloroquine or related compounds

Smallpox

Smallpox, Influenza (FluMist®)
Steroids, prednisone, cortisone, or anti-cancer drugs? □ □ MMR or components, Oral typhoid, Varicella, Yellow fever, influenza (Flu Mist®, MMRV, Zoster Vaccine Live (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, Influenza (FluMist®)

Medications for depression or emotional problems? □ □ Mefloquine

Medication for convulsions? □ □ Mefloquine

**Allergies**

<table>
<thead>
<tr>
<th>ARE YOU ALLERGIC TO:</th>
<th>Yes</th>
<th>No</th>
<th>Problem*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any medications?</td>
<td>□</td>
<td>□</td>
<td>Rabies (PCEC)</td>
</tr>
<tr>
<td>• Amphotericin B?</td>
<td>□</td>
<td>□</td>
<td>Diamox®, Fansidar®, Penicillin, Sulfadiazine</td>
</tr>
<tr>
<td>• Penicillin or sulfa?</td>
<td>□</td>
<td>□</td>
<td>DT (multi-dose). Tetanus toxoid (multi-dose; booster), Influenza (Fluzone Multi-dose; Fluvirin), Japanese Encephalitis, Meningococcal (Meningococcal multidose).</td>
</tr>
<tr>
<td>• Mercury or thimerosal? (Only vaccines containing more than a trace amount of thimerosal are listed.)</td>
<td>□</td>
<td>□</td>
<td>Hepatitis AVB (Twinrix®), influenza, IPV, MMR or components, Rabies (HDCV and PCEC), Varicella Zoster Vaccine Live (Zostavax®) Smallpox, PEDIARIX™, MMRV, TBE</td>
</tr>
<tr>
<td>• Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)</td>
<td>□</td>
<td>□</td>
<td>Influenza (Fluvirin®), IPV, Smallpox, PEDIARIX™ Doxycycline</td>
</tr>
<tr>
<td>• Polymyxin?</td>
<td>□</td>
<td>□</td>
<td>Doxycycline</td>
</tr>
<tr>
<td>• Sulfites?</td>
<td>□</td>
<td>□</td>
<td>Hep A, Hep B, Hep, A/B (Twinrix®), COMVIX™, DTap, Td, Rabies (RVA), Anthrax, Pneumococcal (PCV), Tdap TBE, HPV (Gardasil®) Anthrax</td>
</tr>
<tr>
<td>• Aluminum or aluminum hydroxide?</td>
<td>□</td>
<td>□</td>
<td>Hep B, Hep. A/B (Twinrix®), IPV, DTap (Infanrix™, PEDIARIX™), Tdap (ADACEL™)</td>
</tr>
</tbody>
</table>
• Bee stings or history of hives or urticaria? □ □ Japanese encephalitis

• Yeast? □ □ Hep. A (Havrix®), Hep. A/B (Twinrix®), HPV (Gardasil®)

• Eggs? □ □ Influenza, Rabies (PCEC), Yellow fever, MME or components, MMRV, TBE

• Glycerin or chlortetracycline? □ □ Smallpox

Are you hypersensitive to gelatin? □ □

Are you hypersensitive to beef protein, soy casein, lactose, phenol, or formaldehyde? □ □

*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.

I attest that the above information is accurate and complete to the best of my knowledge. I understand that, because of my participation in this trip and travel medicine appointment, I will be advised by a healthcare provider affiliated with the Carroll County Health Department as to the required and/or recommended immunizations, and medications for my trip. It is my responsibility to comply with their recommendations. I understand that refusing recommended medications or immunizations could result in serious medical illness. I understand that this consultation does not represent a medical clearance for travel. I will not hold the Carroll County Health Department responsible should I contract illnesses or suffer injury associated with this trip.

SIGNATURES: ___________________________________________ (Traveler and Date) ___________________________________________ (Health Care Provider and Date)

The information in this questionnaire is not a substitute for medical advice from a health care provider on an individual basis. This form may be enlarged, copied and used for patient care.
Patient Questionnaire

Please give this document to the clerk when you are finished.

OVERSEAS WORKSHEET

Date: ___________________ Patient label__________________________
Recent Travel: ________________________________________________________________________________
___________________________________________________________________________________________
Current Meds: ___________________________ Preferred Phone: ______________________________________
___________________________________________________________________________________________
Work Phone: __________________________________________________________________________________
___________________________________________________________________________________________
Age: ______ Date of birth: _________________
Allergies: ___________________________ Sex: M F Weight: __________
___________________________________________________________________________________________
Pregnant: Y N Breastfeeding: Y N
Planning to be pregnant: Y N
Heart, kidney or liver problems: Y N
Allergic to eggs: Y N ; To Thimerosal: Y N
All countries you will visit (in order, first to last): ________________________________________________
___________________________________________________________________________________________
Date of departure: ________________________ Length of trip: ________________________________
Purpose: _____________________________ Urban: __________ Rural: __________ Both: ___________

This box for clinic use only

PLAN:

PHARMACY# _______________________________ R x Chloroquine 500mg# _______________________________
Teaching Checklist
General info: _____ Malaria R x: _______ Mefloquine 250mg# _______________________________
_____ Tdap _____ TD _____ Polio _____ MMR Malarone 250/100mg# _______________________________
_____ Meningococcal Meningitis _____ Yellow Fever Doxycycline 100mg# __________________________
_____ J. Enceph. _____ Typhoid (inj.) _____ Oral Typhoid _____ Hepatitis _____ A _____ B
_____ Imm. Globulin _____ Flu _____ V2V

Work-up prepared by: