



## TRAVEL MEDICINE QUESTIONNAIRE

<b>PLEASE PRINT</b>				
Legal Name of Traveler:				
Gender:	DOB:	Birthplace:		
Home Address:				
City:	State:	Zip:		
Home Phone:		Business Phone:		
Primary Care Physician:		Phone:		
Emergency Notification:		Phone:		
Relationship:				
<b>ITINERARY</b>				
Departure Date:		Return Date:	Length of Trip:	
<b>PURPOSE OF TRAVEL</b>				
<input type="checkbox"/> Business	<input type="checkbox"/> Field Worked	<input type="checkbox"/> Relocation	<input type="checkbox"/> Teaching/Study	<input type="checkbox"/> Missionary Work
<input type="checkbox"/> Vacation	<input type="checkbox"/> Diving	<input type="checkbox"/> Safari	<input type="checkbox"/> Climbing	<input type="checkbox"/> Other
<b>TYPE OF TRAVEL</b>				
<input type="checkbox"/> Group/Tour		<input type="checkbox"/> Independent		<input type="checkbox"/> Fixed Itinerary
<input type="checkbox"/> Flexible Itinerary		<input type="checkbox"/> Cruise		<input type="checkbox"/> Other:
<b>ACCOMMODATIONS</b>				
<input type="checkbox"/> Compound	<input type="checkbox"/> Hotel/Resort	<input type="checkbox"/> Private Home	<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Offshore Rig
<b>DESTINATION, INCLUDING AIRPORT STOPOVERS. LIST IN ORDER OF TRAVEL:</b>				
Country	City	Duration	Urban (X)	Rural (X)

**NOTICE OF ADVANCE PAYMENT REQUIRED**

THIS IS NOTICE TO INFORM YOU THAT MOST HEALTH PLANS DO NOT OFFER COVERAGE FOR IMMUNIZATIONS FOR THE PURPOSE OF TRAVEL. PAYMENT, IN FULL, IS EXPECTED AT THE TIME OF YOUR VISIT. FURTHER, THESE SERVICES ARE NOT SUBJECT TO ANY EXISTING DISCOUNT POLICIES.

YOU MAY CHOOSE TO FILE A CLAIM DIRECTLY WITH YOUR HEALTH PLAN. YOU MAY ALSO CHOOSE TO CONTACT YOUR HEALTH PLAN PRIOR TO THE VISIT TO REQUEST A BENEFITS REVIEW FOR "TRAVEL MEDICINE SERVICES."

REVIEWED AND ACCEPTED: \_\_\_\_\_

Date: \_\_\_\_\_



Immunization History (check "Had Disease" if applicable or list date of appropriate vaccination):					
	Had Disease	Vaccine # 1 date	Vaccine # 2 date	Vaccine #3 date	Not Known
Chickenpox					
Hepatitis A					
Hepatitis B					
Rabies					
Japanese Encephalitis					
Measles					
Mumps					
Rubella					
Meningitis					
Polio					
Pneumococcal					
Influenza					
Tetanus/Diphtheria					
Typhoid Injection					
Typhoid Oral					
Yellow Fever					
Do you have an "International Certificate of Vaccination"?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever fainted or had an adverse reaction to any of the following:					
Vaccines:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Stings:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cancer, leukemia, AIDS or other immune system problems? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you take Cortisone, prednisone, other steroids, anti-cancer drugs or have/had radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you received a blood transfusion, blood products or immune globin in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you had any immunizations in the past 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please explain:					
HEALTH HISTORY					
Weight:		Height:		Allergies:	
MEDICATIONS (LIST ALL MEDICATIONS, INCLUDING DOSAGES)					
Prescription			Non-Prescription		
Medical Conditions:					
Previous Surgery:					
Do you have a history of the following:					
Nightmares: <input type="checkbox"/> Yes <input type="checkbox"/> No		Psoriasis: <input type="checkbox"/> Yes <input type="checkbox"/> No		Seizure/Epilepsy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric Disorders/Depression: <input type="checkbox"/> Yes <input type="checkbox"/> No		Stomach/Colon Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Women: Type of contraception, if applicable:					
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Planning pregnancy within 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No		Nursing: <input type="checkbox"/> Yes <input type="checkbox"/> No	

I verify that the above information is complete and correct to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**\*\*\*PLEASE BRING YOUR YELLOW TRAVEL CARD OR IMMUNIZATION RECORD TO YOUR VISIT\*\*\***