DeKalb PUBLIC HEALTH

Label

Travel Medical Questionnaire – Page 1

Country of birth			
Immunizations	**Yes**	**No**	**Problems**
Have you ever fainted from having your blood drawn or from an injection?	☐	☐	
Have you ever had a fever from vaccination?	☐	☐	
Have you ever had *any* bad reaction/side effect from any vaccination?	☐	☐	
Have you had hepatitis A or B vaccine?	☐	☐	
Do you live (or work closely) with anyone who has AIDS or other immune disease or is on cancer chemotherapy?	☐	☐	
Have you received any injection of immune globulin or any blood product in the past 8 months?	☐	☐	
General Medical			
Do you have a medical condition that needs medication or physician follow-up?	☐	☐	
Do you have a medical condition that is stable now but that may recur while traveling?	☐	☐	
Have you had a fever in the past 48 hours?	☐	☐	
Do you have AIDS, any other immune disorder, or cancers?	☐	☐	
Do you have severe thrombocytopenia (low platelet count) or a clotting disorder?	☐	☐	
Have you ever had a convulsion, a seizure, or epilepsy?	☐	☐	
Do you have any stomach problems?	☐	☐	
Have you ever had hepatitis or yellow jaundice?	☐	☐	
Do you have a history of psychiatric or emotional problems?	☐	☐	
Do you have a problem with strange dreams and/or nightmares?	☐	☐	
Do you have psoriasis?	☐	☐	
Women Only			
Are you pregnant or might you become pregnant on this trip?	☐	☐	
Are you breast feeding?	☐	☐	
Date of your last menstrual period:			
Method of birth control:			
Do you have problems with vaginitis?	☐	☐	
Are you on Hormone Replacement Therapy?	☐	☐	

(Please Turn Over)

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Travel Medical Questionnaire – Page 2

Medications	Yes	No	Problems
ARE YOU TAKING OR WILL YOU BE TAKING:			
Quinine, quinidine, or medication for a heart conduction problem?	☐	☐	
Steroids, prednisone, or cortisone?	☐	☐	
Antibiotics?	☐	☐	
Pepto-Bismol to prevent traveler's diarrhea?	☐	☐	
Antacids?	☐	☐	
List all medication (and treatment) you are taking on a regular basis. (Please Print)			
____________________ ____________________ ____________________			
____________________ ____________________ ____________________			
____________________ ____________________ ____________________			
____________________ ____________________ ____________________			
Allergies	**Yes**	**No**	**Problems**
ARE YOU ALLERGIC TO:			
Any food?	☐	☐	
Penicillin or sulfa?	☐	☐	
Any other medication?	☐	☐	
Bee stings or insect bites?	☐	☐	
Do you have a history of hives or urticaria?	☐	☐	
Tobacco Use			Number of packs per day

Comments or Additional Questions:

Nurse's Signature: ______________________________ **Date:** ____________