

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE

DATE: _____ NAME: _____ AGE: _____ WEIGHT: _____ SEX: _____

DATE OF DEPARTURE: _____

ITINERARY (In chronological order)

No.	Country	Region name(s) if available	Dates/Duration
1			
2			
3			

IMMUNIZATIONS

YES NO

Have you ever had any bad reaction, or side effect, from any vaccine? _____ _____

Have you received an injection of immune globulin or any blood product _____ during the past 8 months? _____

GENERAL MEDICAL

YES NO

Do you have a medical condition that warrants maintenance medications or physician follow-up? _____ _____

Have you had a fever in the past 48 hours? _____ _____

Are you pregnant or might you become pregnant on this trip? _____ _____

Do you have AIDS, an AIDS-like condition, other immune disorder, leukemia, or cancer? _____ _____

Have you ever had a convulsion, seizure or epilepsy? _____ _____

Do you have a history of psychiatric problems? _____ _____

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

Are you taking or will you be taking quinine, quinidine or medications for a cardiac conduction defect? _____ _____

ALLERGIES

YES NO

Are you allergic to any medications, vaccines, bee stings, yeast or eggs? _____ _____

Do you have a history of hives or urticaria? _____ _____

Signature: _____ Please fax us a copy of your child's vaccination record as soon as possible so we can make an accurate assessment of the travel immunization needs.