**Pre-Travel Questionnaire**

*Please complete this form to the double line only.*

**Section One - Personal Information and Itinerary**

Name: ___________________________ Today’s Date: ______________________

Who referred you to our clinic? __________________________________________________________________________

Age: _______ Date of Departure: ______________ Date of Return: ______________

Purpose of Travel:  □ Pleasure/vacation □ Religious □ Business/education

(Company Name/Affiliation)

How many times have you traveled to developing countries?  □ Never

□ One  □ Twice  □ Three times  □ Four or more times

Have you ever traveled to Europe?  □ No  □ Yes

Countries on Itinerary (in order of travel and note major forms of transportation):

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>MODES OF TRANSPORTATION</th>
<th>EXPECTED DURATION OF STAY</th>
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<tbody>
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<td>Cities</td>
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<td>c.</td>
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</table>

Check all that apply to your travel plans.

□ Major resort hotels  □ Staying with a family  □ Rural travel

□ Small hotels  □ Cruise ship  □ Outdoor activities

□ Youth hostel  □ Camping  □ Organized tour group

□ Rented foreign home  □ Safari  □ Other (please specify)

Will you be participating in physically strenuous activities (skiing, mountain climbing, SCUBA diving, hiking, activities at above 5,000 feet?)

□ No  □ Yes

If yes, have you been involved in conditioning activities?

□ No  □ Yes
Section Two - Personal Health Issues

Allergies
- Bee/insect sting
- Seasonal
- Thimerosal/mercury
- Eggs
- Drugs
  1. __________________
  2. __________________

Allergy Medications
  1. __________________
  2. __________________
  3. __________________

- No known allergies

Significant Medical Conditions
- Altitude sickness
- Anemia
- Asthma
- Blood clots
- Blood transfusion in the last year
- Cancer
- Depression or other psychiatric disorder
- Diabetes (H)
  - Insulin dependent
- Eye disease
- Stomach/intestinal problems
  - G6PD deficiency
  - Hearing impaired
  - Heart disease
- Requirement oxygen
- Pacemaker

- Hypertension
- Hepatitis

- HIV/AIDS
- Immune deficiency
- Liver disease
- Lung disease
- Require oxygen
- Lyme Disease
- Malaria
- Motion sickness
- Neurologic disease
- Parasitic diseases
- Physically challenged
- Psoriasis
- Pregnancy (H)
  - Due Date: ___________

- Sickle cell disease
- Splenectomy
- Past travel illness with jaundice
- Traveler's diarrhea
- Other:
  _______________________
- None

Do you currently take any medications or food supplements?  □ No □ Yes
If yes, please list the name of the medication, indication, and dose. List both prescription and over-the-counter medications.

________________________________________________________________________
________________________________________________________________________

Have you received a transfusion of blood products in the last 6 months?  □ No □ Yes
If yes, indicate the blood type and date: _______________________

Section Three - Immunizations

Usual childhood vaccinations □ No □ Yes
Vaccinations as an adult □ No □ Yes If yes, please indicate below which ones and most recent date.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Date</th>
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<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
<td>MMR booster</td>
<td></td>
<td>TB Skin test</td>
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<tr>
<td>Hepatitis B</td>
<td></td>
<td>Pneumovax</td>
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<td>Tuberculosis BCG</td>
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<tr>
<td>Influenza</td>
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<td>Polio</td>
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<td>Typhoid</td>
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<td>Japanese</td>
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<td>Rabies</td>
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<td>Oral</td>
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<td>Encephalitis</td>
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<td>Tetanus/</td>
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<td>Injection</td>
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<tr>
<td>Meningococcus</td>
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<td>Diphteria</td>
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<td>Varicella</td>
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<td>Yellow fever</td>
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<td>Other</td>
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</table>
Do you work closely with anyone who has AIDS or who otherwise has an immune deficiency?  
☐ No  ☐ Yes

Have you used malaria prophylaxis medications in the past?  ☐ No  ☐ Yes

If yes, please indicate below which ones.

☐ Mefloquine (Lariam)  ☐ Primaquine
☐ Chloroquine (Aralen)  ☐ Doxycycline
☐ Hydroxychloroquine (Plaquinil)  ☐ Maloprim
☐ Proguanil  ☐ Malarone

(H) - Handout available
Section Four - Counseling

Pre-Trip Counseling Areas

☐ Travel insurance (H)
  ☐ emergency treatment
  ☐ emergency evacuation
  ☐ trip cancellation
  ☐ information given
☐ Travel medicine kit (H)
☐ Conditioning for athletic trip

☐ Motion sickness
☐ Tanning to prevent sunburn
☐ Time zone adjustment
☐ Jet lag (H)

☐ Arrangements for medical needs
  (O₂, transportation, dietary, etc.)
☐ Carry-on medications
☐ Dental status

In-Flight Counseling Areas

☐ Hydration (low humidity)
☐ Effects of alcohol at high altitude
d ☐ Effects of caffeine at high altitude

☐ Time zone adjustment
☐ In-flight activity to reduce clotting
d ☐ Lumbar and neck support

Destination Counseling Areas

☐ Traveler’s diarrhea
  ☐ food and water precautions
  (“cook it, peel it, open it, or forget it”)
  ☐ medical attention for symptoms
  (X 3 days, bloody, fever)
☐ Sun protection (on water or snow)
  ☐ SF 30, UV A & B
d ☐ Sun glasses
☐ Blood supply in developing countries

☐ Insect precautions (H)
  DEET: _____% ☐ Permethrin
☐ Water precautions
☐ Auto safety
  ☐ Rentals (check seatbelts, signals, etc)
  ☐ Local driving laws
  ☐ What side of the road?
☐ Safe sex precautions
☐ Sexual harassment
☐ Local laws and customs
  ☐ women’s dress/appearance

Post-Trip Counseling Areas

☐ Follow-up appointment indicated
☐ Follow-up TB skin test indicated

Indications for follow-up:
  ☐ Persistent fever or diarrhea
  ☐ New persistent cough
  ☐ Unexplained weight loss
  ☐ Night sweats

Section Five - Assessment and Recommendations

Height: _______  Weight: _________  Temp: _________  Pulse: _________

Medication letter given:
  ☐ Not Indicated ☐ Yes Date sent:_______  ☐ No
  ☐ Needles and syringes

Adequate prescription medications for trip:
  ☐ Yes  ☐ Not applicable
  ☐ No  ☐ Prescriptions written
  ☐ Referred to primary physician
Post-trip evaluation recommended?  □ No  □ Yes  Date:__________
(Recommend for trip over 3 months in duration or for specific health problems.)

**Immunizations**
(usual adult doses)

1. □ Hepatitis A<sup>a,k</sup> vaccine (Vaqta, Havrix)
2. □ Hepatitis B<sup>b</sup> (1.0 ml days 0, 30, 180)
3. □ Immune globulin<sup>g,k</sup> (2.0 ml IM)
4. □ Influenza<sup>d,e</sup> (0.5 ml IM)
5. □ Japanese encephalitis<sup>c,g,h</sup> (days 0, 7, 30)
6. □ MMR booster<sup>d,g</sup> (0.5 ml IM)
7. □ Meningococcus<sup>a,b,k</sup> (0.5 ml SC)
8. □ Pneumovax (0.5 ml IM/SC)
9. □ Polio
   □ Injectable (0.5 ml SC)
10. □ Rabies (0.1 ml IM or 0.1 ml ID days 0, 7, 21/28)
11. □ Tetanus/Diphtheria<sup>e</sup> (0.5 ml IM)
12. □ TB Skin Test
13. □ Typhoid<sup>n,b</sup>
   □ Typhim Vi (0.5 ml IM)
   □ Oral<sup>f</sup> (1 po QOD x 4)
16. □ Varicella<sup>f</sup> 0.5cc sub-q; second 4-8 wks
17. □ Yellow fever<sup>a,c,d</sup> (05 ml sC)
18. □ Other

a. Not recommended in pregnancy.
b. Contraindicated if allergic to thimerosal.
c. Live virus vaccines should be 2 weeks before or 3 months after immune globulin.
d. Avoid during first trimester.
e. Contraindicated if allergic to eggs.
f. Not recommended during pregnancy unless there is significant risk.
g. Caution for those with hymenoptera allergy.
h. Only if immediate protection is needed.
i. Do not take while on antibiotics.
j. ISG/HRI/G/HBIG 4 months, Varicella 5 months, blood transfusion 6 months

**Immunizations Given**

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<tr>
<th>Immunization Number</th>
<th>Vaccine Lot Number</th>
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Administered by:_________________________  Date:_________________________

**Malaria Prophylaxis**
(All given 2 weeks pre-departure through 4 weeks post-travel) (H)

□ No prophylaxis recommended.
□ Mefloquine (Lariam) 250 mg/week  (Rx #____________________)
   (Not for use with beta blockers, calcium channel blockers, pregnancy, history of epilepsy or psychiatric problems)
□ Chloroquine (Aralen) 500 mg/week  (Rx #____________________)
   (Lessen side effects by taking with meals or divided into twice weekly doses. Contraindicated with psoriasis.)
□ Doxycycline (Vibramycin) 100 mg/day  (Rx #____________________)
   (Not for use with pregnancy, children younger than 8 years. Do not take with dairy products.)
□ Pyramethamine 25 mg/week  (Rx #____________________)
□ Proguanil recommended in country of travel.
□ For women of child bearing age: advise to use reliable birth control methods while taking malaria prophylaxis.
□ Primaquine

(H) - Handout available  (Continued)
Traveler’s Diarrhea Prophylaxis

- No prophylaxis recommended.
- Bismuth Subsalicylate (Pepto Bismol) 2 tabs QID
  (Not to be taken with aspirin hypersensitivity, history of gout, use of anticoagulants or hypoglycemic agents. Limit to use less than 3 times per week. Tongue and/or stool may turn black. Not recommended for children.)
- TMP/SMX* DS BID (avoid concentrated sunlight) (Rx # ____________________)
  (Up to 14% with rashes if used for 2-3 weeks)
- Ciprofloxin* 500 mg qD (Rx # ____________________)
- Doxycycline* 100 mg qD (Rx # ____________________)
- Imodium AD
  (Caution: Diphenoxylate (Lomotil) may actually increase risk.)
- Lactinex chewables (acidophilis) (Rx # ____________________)
- Other: ________________________________

Self-Treatment for Traveler’s Diarrhea (H)

- None recommended
- Pepto-Bismol and Imodium AD
- TMP/SMX DS BID x 3-5 days (Rx # ____________________)
- Ciprofloxin 500 mg BID x 3 days (Rx # ____________________)
- Livoquin 500 mg qd x 3 d (Rx # ____________________)
- Doxycycline 100 mg BID x 3 days (Rx # ____________________)
- Loperamide 4 mg loading, 2 mg after each unformed stool (8 mg/d max)
  (Caution: do not use if stool is bloody or diarrhea is accompanied by fever or over 3 days in duration.)
- Other: ________________________________

Other Recommendations:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Session: Singe/Group for ___________ minutes.
Completed by: ________________________________
Date: ________________________________

Reviewed History and Recommendations – Concur: ________________________________

(H) - Handout available