

Travel Medicine Questionnaire

Please fill out to the best of your ability. Information is for medical use only and will be kept strictly confidential

Last Name:		Sex:		<input type="checkbox"/> Female		<input type="checkbox"/> Male	
First, Middle Names:		Date of Birth:	Year	Month	Day		
Address:		Emergency contact:					
		Name:					
		Phone:					
Phone:	Relationship:						
E-mail:	Referred by:						
Guardian(if patient is a minor):					Relationship:		
MEDICAL HISTORY							
CURRENT / PAST HEALTH PROBLEMS:				CURRENT MEDICATIONS:			
For women	Are you: <input type="checkbox"/> currently pregnant <input type="checkbox"/> possibly pregnant <input type="checkbox"/> planning to become pregnant in the next 3 months						
	Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last menstrual period:						
HABITS:	Tobacco: _____ packs/day for _____ years			Alcohol: _____ drinks/ozs/mls per day			
ALLERGIES (including medications, food):							
TRAVEL DETAILS							
DESTINATION(S):							
DATE OF DEPARTURE:				DATE OF RETURN:			
ANTICIPATED TRAVEL CONDITIONS (check all that apply)							
<input type="checkbox"/> organized group travel		<input type="checkbox"/> independent travel		<input type="checkbox"/> hotel stays			
<input type="checkbox"/> dormitory / hostel stays		<input type="checkbox"/> private home stay		<input type="checkbox"/> visiting friends / relatives			
<input type="checkbox"/> camping / hiking / trekking		<input type="checkbox"/> working with animals		<input type="checkbox"/> providing healthcare			
<input type="checkbox"/> high altitude locations		<input type="checkbox"/> other:					