GOVERNMENT OF BERMUDA
Ministry of Health and Environment
Department of Health

TRAVEL MEDICINE SERVICE
Trip Planning Questionnaire

Travellers: at the beginning of each new trip, please answer the questions on this sheet as best as you can. It will help us to help you.

FIRST Name ______________ *LAST* Name ______________ Middle Initial(s) ________

Address ____

Telephone: Home ______________ Work ______________ Cell ______________

Birth Date (dd/mm/yyyy) ______________ Age ________ Sex ☐ M ☐ F

ITINERARY (List countries and dates in order of travel)

Departure Date ______________ Return Date ______________

Total Length of Trip ________ Days ________ Weeks ________ Months ________ Years

Country ______________ Duration ______________ ☐ Rural ☐ Urban

Country ______________ Duration ______________ ☐ Rural ☐ Urban

Country ______________ Duration ______________ ☐ Rural ☐ Urban

Country ______________ Duration ______________ ☐ Rural ☐ Urban

PURPOSE OF TRAVEL

☐ Business ☐ Vacation ☐ Field Work ☐ Missionary ☐ Teacher ☐ Climbing ☐ Diving

☐ Volunteer Agency ☐ Foreign Study ☐ Other ______________

TYPE OF TRAVEL

☐ Guided or escorted tour ☐ Independent travel (fixed itinerary) ☐ Independent travel (flexible itinerary)

ACCOMMODATION(S)

☐ Hotel/Resort ☐ Private Home ☐ Rented Foreign Home ☐ Safari/Camp ☐ Youth Hostel

☐ Other ______________

PRIOR IMMUNIZATIONS AND REACTIONS

Diphtheria/Tetanus ______________ Hepatitis A ______________

Tetanus ______________ Immune Globulin ______________

Typhoid ______________ Hepatitis B ______________

Cholera ______________ Meningococcal Vaccine ______________

Yellow Fever ______________ Polio ______________

Mumps/Measles/Rubella ______________ Other ______________

Did you have any reactions to any of the above? ☐ Yes ☐ No

HEALTH SUMMARY (Please answer completely)

MEDICAL CONDITIONS

1. Do you have a history of any of the following?
   - Psoriasis/Lupus/Rheumatoid Arthritis ☐ Yes ☐ No
   - Seizure Disorder/Epilepsy ☐ Yes ☐ No
   - Hepatitis ☐ Yes ☐ No
   - Heart Rhythm Problems ☐ Yes ☐ No
   - Psychiatric Disorder ☐ Yes ☐ No
   - Renal Problems ☐ Yes ☐ No
   - Thyroid Problems ☐ Yes ☐ No
2. Do you have any other current medical conditions not mentioned above? ☐ Yes ☐ No

   If Yes, please detail: ______________________________

CURRENT MEDICATIONS AND ALLERGIES

3. Do you take any of the following medications?
   - Quinidine ☐ Yes ☐ No
   - Digoxin ☐ Yes ☐ No
   - Calcium channel blockers (e.g.Verapamil) ☐ Yes ☐ No
   - Beta blockers (e.g. Inderal) ☐ Yes ☐ No
   - Any other heart medications ☐ Yes ☐ No
   - Anti-seizure medication ☐ Yes ☐ No
   - Anti-coagulants (e.g. Coumadin/Warfarin) ☐ Yes ☐ No
4. Are you currently taking any medications (e.g. chemotherapy, steroids, over-the-counter drugs)? ☐ Yes ☐ No

   If Yes, please list: ______________________________

5. Are you allergic to any drugs or vaccines or foods (e.g. eggs, chicken products)? ☐ Yes ☐ No

   If Yes, please list: ______________________________

OTHER

6. Are you pregnant or considering trying to become pregnant during your stay abroad? ☐ Yes ☐ No
7. Are you at risk for immune deficiency? ☐ Yes ☐ No
8. Last Menstrual Period (if applicable) ____/____/____

PLANNED IMMUNIZATIONS (Physician to complete this section)

Tetanus/Diphtheria ______________________

Tetanus/Diphtheria/Acellular Pertussis ______________________

Typhoid ______________________

Meningococcal Vaccine ______________________

Polio ______________________

Other ______________________

Hepatitis A #1 ________ #2 ________

Influenza ______________________

Hepatitis B #1 ________ #2 ________ #3 ________

Yellow Fever ______________________

Mumps/Measles/Rubella ______________________

Malaria Rx ______________________

Physician's Signature ______________________ Date ____________