



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

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 _____	Hepatitis A #1 _____	#2 _____
Tetanus/Diphtheria/Acellular Pertussis _____	Influenza _____	
Typhoid _____	Hepatitis B #1 _____	#2 _____ #3 _____
Meningococcal Vaccine _____	Yellow Fever _____	
Polio _____	Mumps/Measles/Rubella _____	
Other _____	Malaria Rx _____	

Physician's Signature _____ Date _____