

TRAVEL MEDICINE SERVICE Trip Planning Questionnaire

Travelers: 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.

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FIRST NAME		MIDDLE INITIAL(S)		LAST NAME				Gender MALE			
ADDRESS			DATE OF BIRTH (dd/mm/yyyy)			AGE (years)			FEMALE		
EMAIL			TELEPHONE: Work			TELEPI	HONE:	Home			
HAVE YOU ATTENDED THE TRAVEL HEALTH CLINIC PREVIOUSLY? If Yes, in wh				nat year? TELEPHONE			HONE:	Cell			
□ Yes	□ No				-						
Where are you going? - IT	PURPOSE OF TRAVEL				WHAT KIND OF TRAVELLER ARE						
(List countries and dates, in o	PURPOSE OF TRAVEL				Y	/OU?					
DEPARTURE DATE	RETURN DAT	E			Busin	ess		Travelling with	young childre	n	
TOTAL LENGTH OF TRIP				_	Vaca	tion		Have a ch	ronic disease)	
	antha	Vaara	Mission/E	Mission/Disaster Relief □			(e.g. heart disease, diabetes) □				
DaysWeeksI Country 1		MonthsYear s) Rural or Urban		Spo	Recreational		Passenger on a Cruise Ship				
Country 1	Baration (days	, rara	r or orbarr	·		Activity		Extended Stay (over 30 day			
									r Study Abro	ad	
Country 2 Duration (da		s) Rura	l or Urban	WHERE W		ILL YOU STAY:		Immune-compro	-		
					Hotel/I	el/Resort □		i.e. with cancer or			
Country 3 Duration (day		s) Rura	l or Urban	an Pri		ate Home		taking drugs that	reduce immun	ty)	
				;	Safari/Can	np-site		Pro	egnant Woma	ın	
					Youth	Hostel		Visiting Fri	ends or Fami	lv	
Country 4 Duration (da		s) Rura	l or Urban		Cruise			Violing		-	
				0		Other □			Oth	er	
					01	:her □]				
PERS	ONAL MED	ICAL HIST	ORY		Of	:her □		MUNIZATION H			
PERS Do you have a history of signif		ICAL HIST		king any	O1	ther □	IMI			Y/N	J
	ficant		rrently tal	king any		√ RE	IMI CEIV		HISTORY REACTION		
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TRAVEL MEDICINE SERVICE TO BE COMPLETED BY DOH STAFF ONLY Prophylaxis and/or Vaccines **Additional Comments** Required Recommended/Routine Influenza **Typhoid** Cholera Hepatitis A Yellow Fever Hepatitis B Japanese Encephalitis MMR Meningococcal Rabies Tick-borne Encephalitis Polio Malaria Tdap/Td **Health Care Provider Objective Review & Assessment** Have you reviewed the Personal Medical History, as reported on Trip Planning Questionnaire? YES \square NO \square PLANNED IMMUNIZATIONS & PROPHYLAXIS (Physician to complete this section) Cholera _____ Tetanus/Diphtheria (Td) □ ____ Tetanus/Diphtheria/Acellular Pertussis (TdaP) □ _____ Jap. Enceph.#1 □ _____ Jap. Enceph.#2 □ ____ Typhoid □ Meningococcal Vaccine ______ Influenza 🗆 _____ Rabies #1 $\ \square$ Measles/Mumps/Rubella (MMR) □ _____ Rabies #2 $\ \square$ Rabies #3 $\ \square$ Hepatitis B #1 ______ Hepatitis B #2 $\ \square$ Varicella ______ Hepatitis B #3 $\ \square$ Other \square _____ Yellow Fever \square Other _____ Hepatitis A #1 □ Malaria Rx □ _____ Hepatitis A #2 _____ PHYSICIAN'S SIGNATURE DATE