Government of Bermuda
Department of Health (DOH)

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*

FIRST NAME	MIDDLE INITIAL(S)	LAST NAME	Gender
			MALE ☐ FEMALE ☐
ADDRESS	**DATE OF BIRTH (*dd/mm/yyyy*)**	**Age**	
EMAIL	**TELEPHONE: Work**	**TELEPHONE: Home**	**TELEPHONE: Cell**

Where are you going? - ITINERARY *(List countries and dates, in order of travel)*

DEPARTURE DATE	RETURN DATE

TOTAL LENGTH OF TRIP
_____Days _____Weeks _____Months _____ Years

Country 1	*Duration (days)*	*Rural or Urban*
Country 2	*Duration (days)*	*Rural or Urban*
Country 3	*Duration (days)*	*Rural or Urban*
Country 4	*Duration (days)*	*Rural or Urban*

TO BE COMPLETED BY DOH STAFF ONLY
Prophylaxis and/or Vaccines

Required		Recommended/Routine	
Typhoid	☐	Influenza	☐
Cholera	☐	Hepatitis A	☐
Yellow Fever	☐	Hepatitis B	☐
Japanese Encephalitis	☐	MMR	☐
Rabies	☐	Meningococcal	☐
Tick-borne Encephalitis	☐	Polio	☐
Malaria	☐	Tdap/Td	☐

PURPOSE OF TRAVEL

Business ☐
Vacation ☐
Mission/Disaster Relief ☐
Sports/other Recreational Activity ☐

Where will you stay:
Hotel/Resort ☐
Private Home ☐
Safari/Camp-site ☐
Youth Hostel ☐
Cruise Ship ☐
_____Other ☐

WHAT KIND OF TRAVELLER ARE YOU?

Travelling with young children ☐
Chronic disease *(e.g. heart disease, diabetes)* ☐
Passenger on a Cruise Ship ☐
Extended Stay *(over 30 days)*/Study Abroad ☐
Immune-compromised Traveler
i.e. with cancer or other illness ☐
***or** taking medicines that reduces immunity)* ☐
Pregnant Woman ☐
Visiting Friends or Family ☐
Other ☐
_____

LAST IMMUNIZATION DATE & REACTION

☐ Diphtheria/Tetanus _____ Yes / No
☐ Tetanus/diphtheria/pertussis (Tdap)_____ Yes / No
☐ Typhoid _____ Yes / No
☐ Cholera _____ Yes / No
☐ Yellow fever _____ Yes / No
☐ Measles/Mumps/Rubella _____ Yes / No
☐ Hepatitis A _____ Yes / No
☐ Hepatitis B _____ Yes / No
☐ Immune Globulin _____ Yes / No
☐ Meningococcal _____ Yes / No
☐ Polio _____ Yes / No

If YES to any, describe_____

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following medical conditions?

Psoriasis/Lupus/Rheumatoid Arthritis ☐
Seizure Disorder/Epilepsy ☐
Hepatitis ☐
Heart rhythm problems ☐
Psychiatric Disorder ☐
Renal (Kidney) Problems ☐
Thyroid Problems ☐
Any condition not mentioned above ☐
List: _____

Are you currently taking any of the following medications?

Quinidine ☐
Digoxin ☐
Calcium Channel Blocker (*e.g. Verapamil*) ☐
Beta-blockers (*e.g. Inderal*) ☐
Any other heart medications ☐
Anti-seizure medication ☐
Anti-coagulants (*e.g. Coumadin/Warfarin*) ☐
Any medication(s) not mentioned above ☐
List: _____

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

Are you pregnant or currently trying to become pregnant? Yes ☐ No ☐

Do you have any condition that affects your immune system? Yes ☐ No ☐

For Women: Date of your last menstrual period: _____

TODAY'S DATE		TRAVELLER'S SIGNATURE	

TRAVEL MEDICINE SERVICE

Health Care Provider Objective Review & Assessment

PLANNED IMMUNIZATIONS & PROPHYLAXIS (Physician to complete this section)

Tetanus/Diphtheria (Td) ☐ _____	Cholera ☐ _____
Tetanus/Diphtheria/Acellular Pertussis (TdaP) ☐ _____	Jap. Enceph.#1 ☐ _____
Typhoid ☐ _____	Jap. Enceph.#2 ☐ _____
Meningococcal Vaccine ☐ _____	Influenza ☐ _____
Polio ☐ _____	Rabies #1 ☐ _____
Measles/Mumps/Rubella (MMR) ☐ _____	Rabies #2 ☐ _____
Hepatitis B #1 ☐ _____	Rabies #3 ☐ _____
Hepatitis B #2 ☐ _____	Varicella ☐ _____
Hepatitis B #3 ☐ _____	Other ☐ _____
Yellow Fever ☐ _____	Other ☐ _____
Hepatitis A #1 ☐ _____	
Hepatitis A #2 ☐ _____	Malaria Rx ☐ _____

PHYSICIAN'S SIGNATURE	**DATE**