BRANCH HILLSDALE ST. JOSEPH COMMUNITY HEALTH AGENCY
INTERNATIONAL TRAVEL SERVICE

Traveler: _____ Date: _____
Address: _____ City_____ Zip_____
Phone: _____ Date of Birth: _____ Number in travel party: _____
Travel Itinerary: Include arrival and departure date with each country
_____
_____
_____
Travel type/purpose: _____

YES	NO	General Medical
_____	_____	1. Do you have a medical condition that warrants maintenance medications or physician follow-up?
_____	_____	2. Do you have a medical condition that is stable now, but that might recur during traveling?
_____	_____	3. Have you had a fever in the past 48 hours?
_____	_____	4. Are you pregnant or might you become pregnant on/before this trip?
_____	_____	5. Do you have AIDS, an AIDS-like condition, and other immune disorder, leukemia, or cancer?
_____	_____	6. Do you have severe thrombocytopenia (low platelet count) or a blood clotting disorder?
_____	_____	7. Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?
_____	_____	8. Do you have any stomach condition?
_____	_____	9. Do you have a G6PD deficiency?
_____	_____	10. Do you have bowel conditions such as diarrhea or constipation?
_____	_____	11. Have you ever had hepatitis or yellow jaundice?
_____	_____	12. Do you have a history of psychiatric problems?
_____	_____	13. Do you have a problem with strange dreams or nightmares?
_____	_____	14. Do you have insomnia?
_____	_____	15. Do you have problems with vaginitis?
_____	_____	16. Do you have psoriasis?
_____	_____	17. Have you or a member of your household ever bee diagnosed with eczema or atopic dermatitis (e.g. itchy, red, scaly rash lasting >2 weeks that often comes and goes)?
_____	_____	18. Do you have a history of cardiac disease, with or without symptoms?

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Name of Traveler: _____

YES	NO	General Medical (continued)
_____	_____	19. Do you have any eye conditions? _____
_____	_____	20. Are you prone to motion sickness?
_____	_____	21. Have you ever fainted from having your blood drawn or from an injection?
_____	_____	22. Have you ever had: _____ Hepatitis A vaccine _____ Hepatitis B Vaccine?
_____	_____	23. Do you live or work closely with anyone who has AIDS, and AIDS-like condition, an immune disorder, or who is chemotherapy for cancer?
_____	_____	24. Do you have a family history of immunodeficiency?
_____	_____	25. Have you received an injection of immune globulin or any blood product during the past 12 months?
_____	_____	26. Have you had Thyroid disease?
_____	_____	27. Have you had Myasthenia Gravis or Thymus disease?
_____	_____	28. Have you ever had a fever reaction to vaccination?

YES	NO	MEDICATIONS--Are you taking, or will you be taking:
_____	_____	1. Quine, quinidine, or medications for a cardiac conduction problem?
_____	_____	2. Chloroquine, mefloquine, or proguanil to prevent malaria?
_____	_____	3. Steroids, prednisone, cortisone, or anti-cancer drugs?
_____	_____	4. Antibiotics? _____
_____	_____	5. Pepto-bismol to prevent travel's diarrhea?
_____	_____	6. Antacids?
_____	_____	7. Oral Contraceptives?
_____	_____	8. Aspirin therapy (children & adolescents)?
_____	_____	9. Medications for emotional problems?
_____	_____	10. Medication for convulsions or seizures?

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YES	NO	ALLERGIES--Are you allergic to:
_____	_____	1. Amphotericin B?
_____	_____	2. Penicillin or sulfa?
_____	_____	3. Mercury or thimerosal?
_____	_____	4. Aminoglycoside antibiotics(streptomycin, neomycin, kanamycin, gentamycin)?
_____	_____	5. Polymyxin?
_____	_____	6. Sulfites?
_____	_____	7. Medications not listed above: _____
_____	_____	8. Aluminum or aluminum hydroxide?
_____	_____	9. Benzethonium chloride?
_____	_____	10. Z-phenoxyethanol?
_____	_____	11. Bee stings or history of hives or red rash?
_____	_____	12. Yeast?
_____	_____	13. Eggs?
_____	_____	14. Glycerin or chlortetracycline?
_____	_____	15. Hypersensitive to gelatin?
_____	_____	16. Hypersensitive to beef protein, soy, casein lactosa, phenol, or formaldehyde?

Signature of client (or responsible party): _____ Date: _____

Signature of Nurse: _____ Date: _____