Travel Vaccination Questionnaire

Please fill in form completely.

Patient's Full Name: _____ Date of Birth: _____ / _____ / _____

Phone: _____ Email Address: _____ Sex: ❑ M ❑ F

Patient's Destination: _____ **Dates of Trip:** _____

Are you currently treated for any medical problems?	❑ Yes ❑ No	*If yes, explain below*
Have you had a significant medical problem in the past?	❑ Yes ❑ No	*If yes, explain below*
Could you be pregnant?	❑ Yes ❑ No	
Are you staying mostly in cities / tourist destinations?	❑ Yes ❑ No	
Are you going to spend time in a rural area?	❑ Yes ❑ No	
Are you going to spend time above 5000 ft?	❑ Yes ❑ No	
Are you going to work in the foreign country?	❑ Yes ❑ No	
Are you allergic to eggs or chicken products?	❑ Yes ❑ No	
Have you had any hypersensitivity or reaction to vaccinations?	❑ Yes ❑ No	*If yes, explain below*
Have you had Guillain-Barre Syndrome?	❑ Yes ❑ No	
Have you had all of your childhood vaccinations?	❑ Yes ❑ No	
Have you had a tetanus/diphtheria vaccination in the last 10 years?	❑ Yes ❑ No	
Have you had a measles vaccination (2 shots)?	❑ Yes ❑ No	
Have you had a polio vaccination as an adult ?	❑ Yes ❑ No	
Have you had a hepatitis A vaccination (2 shots)?	❑ Yes ❑ No	
Have you had a hepatitis B vaccination (3 shots)?	❑ Yes ❑ No	
Have you had a meningitis vaccination in the past 3 years?	❑ Yes ❑ No	
Have you had a typhoid vaccination in the past 2 years (if injected), or in the past 5 years (if oral)?	❑ Yes ❑ No	
Have you had a yellow fever vaccination in the past 10 years?	❑ Yes ❑ No	
Have you had a Japanese encephalitis vaccination in the past 2 years?	❑ Yes ❑ No	

List current or previous significant medical conditions: _____

_____

List current medications: _____

List allergies: _____

Comments: _____

_____

_____

_____

SIGNED: _____ DATE: _____