GNR PUBLIC HEALTH

Place patient label here

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE

Immunizations	Yes	No	Precautions and Contraindications*
1. Have you ever fainted from having your blood drawn or from an injection?	☐	☐	
2. Have you ever had a fever reaction from a vaccine?	☐	☐	DTap, Td, Tdap
3. Have you ever had a bad reaction/side effect from a vaccine?	☐	☐	
4. Have you received a Hepatitis A or B vaccine?	☐	☐	
5. Do you live or work closely with anyone who has AIDS, an AIDS-like condition, any other immune disorder, or who is currently on chemotherapy for cancer?	☐	☐	Influenza (FluMist®), MMR, MMRV, Smallpox (ACAM2000), Varicella
6. Do you have a family history of immunodeficiency?	☐	☐	MMR, MMRV, Smallpox (ACAM2000), Varicella
7. Have you received an immune globulin injection, or any blood product in the past 12 months?	☐	☐	MMR, MMRV, Smallpox (ACAM2000), Varicella
General Medical	**Yes**	**No**	**Precautions and Contraindications***
8. Do you have a medical condition that warrants maintenance medications or physician follow-up?	☐	☐	
9. Do you have a medical condition that is stable now, but may recur while traveling?	☐	☐	
10. Are you currently pregnant or it is possible you become pregnant on this trip?	☐	☐	Doxycycline and other antibiotics. Hepatitis B (Heplisav-B), HPV, Influenza (FluMist®), MMR, MMRV, Oral Typhoid, Smallpox (ACAM2000), Varicella
11. Do you have AIDS or an AIDS-like condition, any other immune disorder, leukemia, or cancer?	☐	☐	Dengue, Influenza (FluMist®), MMR, MMRV, Oral Typhoid, Rabies, Smallpox (ACAM2000), Varicella, Yellow Fever
12. Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?	☐	☐	Yellow Fever
13. Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	☐	☐	Any intramuscular injection
14. Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	☐	☐	DTap, Mefloquine, MMRV
15. Do you have any stomach conditions?	☐	☐	Doxycycline, Mefloquine, Oral Typhoid

General Medical	Yes	No	Precautions and Contraindications*
16. Do you have a G6PD deficiency?	☐	☐	Chloroquine, Primaquine
17. Do you have severe renal impairment?	☐	☐	Malarone
18. Do you have a bowel condition such as diarrhea or constipation?	☐	☐	Rotavirus
19. Have you ever had hepatitis or yellow jaundice?	☐	☐	
20. Do you have a history of depression, generalized anxiety disorder, psychosis, schizophrenia, or other major psychiatric disorder?	☐	☐	Mefloquine
21. Do you have strange dreams and/or nightmares?	☐	☐	Mefloquine
22. Do you have insomnia?	☐	☐	Mefloquine
23. Do you have a history of vaginitis?	☐	☐	Any antibiotic
24. Do you have psoriasis?	☐	☐	Chloroquine or related compounds
25. Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis (e.g., itchy, red, scaly rash lasting > 2 weeks that often comes and goes)?	☐	☐	Smallpox (ACAM2000)
26. Do you have cardiac disease, with or without symptoms?	☐	☐	Influenza (FluMist®), Smallpox (ACAM2000)
27. Do you have any eye conditions?	☐	☐	
Medications	**Yes**	**No**	**Precautions and Contraindications***
Are you taking or will you be taking:			
28. Quinidine, Quinine, or medications for a cardiac conduction defect?	☐	☐	Mefloquine
29. Chloroquine, Mefloquine, or Proguanil to prevent malaria?	☐	☐	Oral Typhoid
30. Cortisone, Prednisone, other steroids, or anti-cancer medicine?	☐	☐	Influenza (FluMist®), MMR, MMRV, Oral Typhoid, Varicella, Yellow Fever
31. Antibiotics or sulfonamides?	☐	☐	Oral Typhoid
32. Antacids or Pepto-Bismol®?	☐	☐	Doxycycline, Tetracycline
33. Oral contraceptives?	☐	☐	Doxycycline, Tetracycline
34. Aspirin therapy (children & adolescents)?	☐	☐	Influenza (FluMist®), Varicella
35. Medication for depression or emotional problems?	☐	☐	Mefloquine
36. Medication for convulsions or seizures?	☐	☐	Mefloquine

37. Please list all medications you are currently taking (including supplements and vitamins):			
Medication Name	**Dosage/ Amount**	**Frequency (times per day, as needed)**	**Route (eye, oral, skin, shot)**

Allergies	**Yes**	**No**	**Precautions and Contraindications***
Are you allergic to:			
38. Any medications?	☐	☐	
39. Amphotericin B?	☐	☐	Rabies (RabAvert)
40. Mercury or thimerosal?	☐	☐	Influenza (multi-dose vials), Td (TDVAX)
41. Aminoglycoside antibiotics (gentamicin, kanamycin, neomycin, streptomycin)?	☐	☐	Hepatitis A, Influenza, IPV, MMR, MMRV, Rabies, Smallpox/Monkeypox, Twinrix, Varicella. Kinrix, Pediarix, Pentacel, Quadracel, Vaxelis.
42. Polymyxin?	☐	☐	Influenza, IPV, Smallpox (ACAM2000). Kinrix, Pediarix, Pentacel, Quadracel, Vaxelis
43. Sulfites?	☐	☐	Doxycycline
44. Aluminum or aluminum hydroxide?	☐	☐	Anthrax, DT, DTaP, Hepatitis A, Hepatitis B, Hepatitis A/B, Hib (PedvaxHIB), HPV, Japanese Encephalitis, PCV, Td, Tdap. Kinrix, Pediarix, Pentacel, Quadracel, Vaxelis.
45. Benzethonium chloride?	☐	☐	Anthrax
46. 2-phenoxyethanol?	☐	☐	DTaP (Daptacel), IPV, Pentacel, Quadracel, Tdap (Adacel)
47. Bee stings or history of hives or urticaria?	☐	☐	Japanese Encephalitis
48. Yeast?	☐	☐	Hepatitis A/B, Hepatitis B, HPV, Pediarix, Vaxelis

Allergies	Yes	No	Precautions and Contraindications*
49. Eggs?	☐	☐	Influenza, Rabies (RabAvert), Smallpox/Monkeypox
50. Glycerin or chlortetracycline?	☐	☐	Rabies (RabAvert), Smallpox (ACAM2000)
51. Are you hypersensitivity to gelatin?	☐	☐	Influenza (FluMist®), MMR, MMRV, Rabies (RabAvert), Typhoid (Vivotif), Varicella, Yellow Fever
52. Are you hypersensitive to beef protein, formaldehyde, lactose, phenol, or soy casein?	☐	☐	Anthrax, Cholera, DT, DTaP, Hepatitis A (Vaqta), Hepatits B (Recombivax), Hib (ActHIB, Hiberix), Influenza, IPV, Japanese Encephalitis, Meningococcal, MMR, MMRV, PPSV, Rabies, Rotavirus, Smallpox (ACAM2000), Td, Tdap, Typhoid, Varicella. Pentacel, Quadracel, Vaxelis.

*Any question with a precaution/contraindication listed above warrants further discussion between the nurse and patient. The questions with precautions/contraindications listed are not all-inclusive, but is representative of common issues that arise in a pre-travel consultation.

The information in this questionnaire is not a substitute for medical advice from your healthcare provider.

_____
Patient (Printed Name)

_____ _____
Patient or Parent/Legal Guardian (Signature) Date Completed

_____
Nurse (Printed Name)

_____ _____
Nurse (Signature) Review Date