



TRAVELER QUESTIONNAIRE

Date: _____

Please fill out this form and bring it with you. Please also bring your immunization records. You may have to check with previous health care providers to get all of this information.

(PLEASE PRINT)

Name:	Date of birth:	Sex: M/ F
Address:	Social Security #:	
Home Phone (_____) _____ - _____	Emergency Contact: _____	

Please list below any diseases and vaccinations you have had, with dates, if possible.

Disease name	Had disease – list date if possible	Had vaccines – list dates
Measles (rubeola)		
Mumps		
Rubella (German measles)		
Chicken Pox (varicella)		

1. Have you received at least 3 doses of tetanus/diphtheria (td) vaccine in the past? (This includes DPT doses received as a child.) **Yes / No**
2. When was your last tetanus/diphtheria shot given? _____
3. Have you received at least 3 doses of polio vaccine, including childhood doses? **Yes / No**
4. Have you ever had an adult polio vaccine? _____
5. Have you ever had Hepatitis A series (#1 and #2)? _____
6. Have you ever had Hepatitis B series (#1, #2 and #3)? _____

Do you have a history of any of the following?

It is vital that we have this information before administering any vaccines.

- Thymus disorder or dysfunction.....yes/no
- Myasthenia Gravis.....yes/no
- Thymoma or Thymectomy.....yes/no
- DiGeorge Syndrome.....yes/no

If yes to any of the above, please explain:

Are you currently being treated for cancer? Yes / No

Do you have a deficiency of the immune system? Yes / No

QUESTIONS FOR WOMEN

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? Yes / No

If pregnant, how many weeks?

Are you breast-feeding? Yes / No

INFORMATION ABOUT YOUR TRAVEL PLANS

Date of Departure: Length of Trip:

Please list below the countries you will be visiting in the order in which you will be traveling. Also indicate length of stay in each country (bring complete details of itinerary to your appointment).

- Are these areas urban/rural?
- Where will you be staying while in these countries? _____
- Are there any unusual circumstances related to your travels? _____

What is the reason for travel (pleasure, business, medical work, etc.)?

If the reason is business or missionary, please indicate the business name and address:

How did you hear about our services?

Do you have any special concerns or questions to be answered at your appointment?

NO INSURANCE NETWORK PARTICIPATION

Dear Traveler:

Travel Health **does not participate** with any insurance providers and therefore, no discounts will be allowed. You are directly responsible for payment at the time of service for immunizations and consultation fees. We accept Cash, Checks, Visa/MasterCard & American Express. We do NOT file insurance claims. A receipt for payment of services will be provided. However, Travel Health does not provide claim forms for services, as we are not set up to generate claims.

TRAVELER SIGNATURE: _____ **Date:** _____