www.IntlTravelCare.com

Travel Safe - Vaccinate

TRAVEL / MEDICAL HISTORY QUESTIONNAIRE

Name:	Phone:	Date:
Address:	Email Address:	

Country of Birth:	Occupation:	M___ F___	Date of birth:	Age:

Primary Care Physician:

Physician Phone:	Physician Fax:

Physician's Address:

Would you like a record of immunizations received today sent to your primary physician? Yes ____ No ____

Have you previously traveled to a developing country? Yes ____ No ____

Departure date:	Return date:

Please list in order all the countries you plan to visit and the length of stay:

1	4
2	5
3	6

TRIP PURPOSE: check all that apply	ACCOMODATIONS: check all that apply	TRIP ACTIVITIES: check all that apply
____ Business	____ Hotel 4 or 5 Star	____ Air travel
____ Vacation	____ Hotel 2 or 3 Star	____ Public transportation e.g. bus, train
____ Study	____ Hostel	____ Biking
____ Missionary	____ Private home	____ Rental car
____ Visiting friends or relatives	____ Camping	____ Water sports e.g. swimming, boating
____ Safari	____ Safari	____ Scuba or Snorkeling
____ Cruise	____ Staying with locals	____ Climbing or Hiking
____ Long stay	____ Long-stay apartment	____ Visiting schools, hospitals, orphanages
____ Volunteer or humanitarian work	____ Cruise Ship	____ Health care worker
		____ Contact with animals

ALLERGIES

Medical allergy? Yes ____ No ____ Which ones?

Vaccine allergy? Yes ____ No ____

Food allergy? Yes ____ No ____

Environmental allergies e.g. hayfever, bee stings? Yes ____ No ____

Latex allergy? Yes ____ No ____ Other:

WOMEN ONLY

Are you pregnant now or is there a possibilty you might be pregnant? Yes _____ No _____

If yes, when are you due?

Are you planning to become pregnant in the next 3 months? Yes ___ No ___