RIVERSIDE URGENT CARE

TRAVEL MEDICINE QUESTIONNAIRE

Patient Name:

DOB:

CLEARLY PRINT ALL INFORMATION

(This form should be completed by the patient and brought to their Travel Immunization appointment)

Legal Name of Traveler:		
Home Address:		
City:	State:	Zip:

Home Phone:	Business Phone:
Primary Care Physician:	Phone:
Emergency Contact:	Phone:
Relationship:	

ITINERARY

Departure Date:	Return Date:	Length of Trip:

PURPOSE OF TRAVEL

☐ Business	☐ Field Work	☐ Relocation	☐ Teaching/Study	☐ Missionary Work
☐ Vacation	☐ Diving	☐ Safari	☐ Climbing	☐ Other

TYPE OF TRAVEL

☐ Group/Tour	☐ Independent	☐ Fixed Itinerary
☐ Flexible Itinerary	☐ Cruise	☐ Other:

ACCOMMODATIONS

☐ Compound	☐ Hotel/Resort	☐ Private/Rented Home	☐ Cruise Ship	☐ Off Shore Rig
☐ Dormitories	☐ Camping	☐ Enclosed Beach Housing	☐ Orphanages	☐ Staying or eating with local families

LIVING ACCOMODATIONS

☐ Screening ☐ Mosquito Netting ☐ Air Conditioning

DESTINATION, INCLUDING AIRPORT STOPOVERS, IN ORDER OF TRAVEL

COUNTRY	CITY	DURATION	URBAN	RURAL

Patient Name: ____________________________________DOB: ____________________ SSN:___________________

IMMUNIZATION HISTORY: (Check "had disease" if applies or list date of vaccine in appropriate box)

	Had Disease	Vaccine #1/Date	Vaccine #2/Date	Vaccine #3/Date	Not Known
Chickenpox (Varicella)					
Hepatitis A					
Hepatitis B					
Influenza					
Japanese Encephalitis					
Measles					
Mumps					
Pneumococcal					
Polio					
Rabies					
Rubella					
Tetanus/Diphtheria					
Typhoid Injection					
Typhoid Oral					
Yellow Fever					

Do you have an "International Certificate of Vaccination"? □ YES □ NO

Have you ever fainted or had an adverse reaction to any:

Vaccines? □ YES □ NO | Bee Stings? □ YES □ NO

Do you have cancer, leukemia, AIDS, or other immune system problems?	□ YES □ NO
Do you take Cortisone, Prednisone, other steroids, anti-cancer Drugs, Antivirals or had radiation therapy?	□ YES □ NO
Have you received a blood transfusion, blood products or immune globulin in the past year?	□ YES □ NO
Have you had any immunizations in the past 4 weeks?	□ YES □ NO

Explain YES answers:

HEALTH HISTORY

Weight:	Height:	Allergies:

MEDICATIONS: (List all medications, including dosages)

Prescription:	Non – Prescription:

Medical Conditions:

Previous Surgery:

Nightmares: □ YES □ NO | Psoriasis: □ YES □ NO | Seizure/Epilepsy: □ YES □ NO

Psychiatric Disorders/Depression: □ YES □ NO | Stomach/Colon Problems: □ YES □ NO

Women: Type of contraception ____(give name brand)

Pregnant? □ YES □ NO | Planning Pregnancy within 3 months?□ YES □ NO | Nursing? □ YES □ NO

I verify that the above information is complete and correct to the best of my knowledge.

_________________________________ Signature

_________________________ Date