International Travel
Returning Traveler Medical Questionnaire

Travel & Immunization Clinic of Portland

Name:_____ Date of Birth: _____ Today's Date: _____
Last First *Month/Day/Year* *Month/Day/Year*

Have you moved or changed your contact information? (circle one) Yes / No

If yes, please list changes:_____

1. Are you pregnant or planning to become pregnant? ☐Yes ☐No
2. Are you breast-feeding? ☐Yes ☐No
3. Are you or any member of your household immune suppressed? ☐Yes ☐No
4. Have you ever fainted from having your blood drawn or from an injection? ☐Yes ☐No
5. Have you received immune globulin/any blood product during the past year? ☐Yes ☐No
6. Have you received any vaccines in the last month? ☐Yes ☐No
7. Do you have thrombocytopenia (low platelet count) or a coagulation disorder? ☐Yes ☐No
8. Have you ever had a convulsion, seizure, epilepsy or neurologic condition? ☐Yes ☐No
9. Have you ever had hepatitis or yellow jaundice? ☐Yes ☐No
10. Do you have a medical condition that may recur while traveling? ☐Yes ☐No
11. Do you have diabetes? ☐Yes ☐No
12. Do you take steroids (Prednisone or other)? ☐Yes ☐No
13. Have you ever had a thymus disorder or dysfunction, including myasthenia gravis, thymoma, thymectomy, or Digeorge syndrome? ☐Yes ☐No
14. Are you feeling sick today, or do you have a high fever? ☐Yes ☐No
15. Have you ever had a bad reaction or side effect from any vaccination? ☐Yes ☐No
16. Are you a smoker, or do you have a history of asthma? ☐Yes ☐No

Allergies

1. Have you ever had an anaphylactic reaction to a vaccine? ☐Yes ☐No
2. I am allergic to eggs ☐Yes ☐No
3. I am allergic to mercury/thimerosal ☐Yes ☐No
4. I am allergic to sulfa drugs ☐Yes ☐No
5. I am allergic to neomycin/streptomycin ☐Yes ☐No
6. I am allergic to latex ☐Yes ☐No
7. **Do you have any other known allergies?** ☐Yes ☐No

If yes, please list: _____

Current medical problems or Changes since we last saw you: _____

Current Medications: _____

What concerns would you like to discuss with your Travel Clinician today? _____

_____

ITINERARY **Departure Date:** _____ **Duration of Trip:** _____

Country	Type of Region	How Long?	Purpose of Trip
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		

_____ I have been offered to review and accept the conditions of the "Patient Rights and Responsibilities," including the Office Fees and Financial Responsibilities

_____ I have been offered to review and accept the conditions of the "Notice of Privacy Practices"