TRAVEL CLINIC QUESTIONNAIRE

For an upcoming appointment with _____ **on** _____

Please complete this online interview in advance of your Travel Clinic appointment. You should bring all records of any past immunizations with you (including copies of childhood vaccines, employment vaccine records, COVID vaccine cards, and/or Yellow Card) to your appointment. NOTE: This questionnaire may take 5-10 minutes to complete.

*Indicates a required field.

*What is your anticipated Date of Departure?

What is your anticipated Date of Return?

How long will your trip be?

Have you ever served in the U.S. Military?

- ☐ Yes
- ☐ No

*What is the purpose of trip? (Select all that apply)

- ☐ Vacation
- ☐ Education/Research
- ☐ Visit Friends/Family
- ☐ Missionary/Volunteer/Humanitarian Relief
- ☐ Work (urban, office-bases, or conference)
- ☐ Work (rural, outdoors, or local community) To obtain medical/dental care)
- ☐ Religious Pilgrimage
- ☐ Other

*If "OTHER" is selected, please describe purpose of the trip.

*Please list the Countries and Locations in order of visit, with arrival and departure dates. (e.g. Lima, Peru March 13-18, 202x)

*Please describe the expected accommodations during your trip. (Select all that apply)

- ☐ Resort/Large Hotel
- ☐ Small Hotel/B&B/Guest House
- ☐ Cruise Ship
- ☐ Private Home (with Locals) Private Home (with Relatives)
- ☐ Private Home (rented or without others)
- ☐ Primitive Camping
- ☐ Up-Scale Camp or Lodge
- ☐ Dormitory/Hostel
- ☐ Other

*If "OTHER" specify accommodations.

*Please describe any planned Activities. (Please list all)

*Will you be in Urban, Rural, or Primitive/Remote setting? (Select all that apply)

- ☐ Urban
- ☐ Rural
- ☐ Primitive/Remote

Please select all activities that you will be doing. (Select all that apply)

- ☐ Ascending to high altitudes (8,000 ft/2438m) or higher.
- ☐ Working with potential exposure to body fluids (medical or dental work)
- ☐ Anticipating close exposure to animals.
- ☐ Potentially having a new sexual partner.
- ☐ SCUBA diving
- ☐ Going on a cruise ship.
- ☐ Visiting friend and/or relatives.
- ☐ Participating in extreme sports (e.g. hand gliding/paragliding, zip linin, cave diving, white water rafting, off-trail skiing, technical mountain climbing, bungee jumping)

*Do you have any history of the following conditions? (Select all that apply)

- ☐ Treatment with steroids by mouth or IV within last 3 months
- ☐ Spleen removed
- ☐ Myasthenia Gravis
- ☐ Thymus condition or thymectomy
- ☐ Organ, Bone Marrow, or Stem Cell transplantation
- ☐ Current taking antacid medication Lung problems (COPD/Emphysema/Asthma
- ☐ Coagulation disorder
- ☐ DVT (Deep Venous Thrombosis) or Blood Clots
- ☐ Diabetes requiring medication
- ☐ Guilain Barre Syndrome
- ☐ Anxiety, Depression, or Mental Health Issues
- ☐ Seizures G6PD deficiency Prior altitude sickness

Do you have any history of treatment with immune suppressive medications or treatments within last 3 months (e.g. radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)?

- ☐ Yes
- ☐ No

*Do you have any history of a malignancy or cancer?

- ☐ Yes
- ☐ No

*If Yes, describe malignancy or cancer including treatment and last date of treatment.

*Do you have any history of HIV?

- ☐ Yes
- ☐ No

If Yes, What was your most recent CD4 count and date?

*Do you have any history of any irregular heartbeat or arrhythmia?

- ☐ Yes
- ☐ No

*Do you have any other significant medical illness that may present issues with travel?

- ☐ Yes
- ☐ No

If Yes, please describe your medical illness.

*Are you pregnant, breastfeeding, suspect you may be pregnant, or trying to become pregnant?

- ☐ Yes
- ☐ No

If Yes, please describe pregnancy status

*What form of contraception are you using? (Enter "None" if not applicable. Some travel medications can react with contraception.)

*Please list any previous destination that have required travel-related evaluations/medications/vaccinations. (Enter "None" if not applicable.)

Have you had any prior travel-related illness?

- ☐ Yes
- ☐ No

If Yes, please describe illness, situation, dates, treatment.

*Have you ever taken malaria medications in the past?

- ☐ Yes
- ☐ No

*Which of the following malaria medication have you taken in the past?

- ☐ Chloroquine (Aralen)
- ☐ Primaquine
- ☐ Mefloquine
- ☐ Doxycycline
- ☐ Atovaquone/Proguanil (Malarone) Tafenoquine (Arakoda, Kozenis, Krintafel)
- ☐ I do not know/cannot remember

*Have you ever had an adverse reaction to malaria medication? (rash, agitation, sleeplessness, nausea)

- ☐ Yes
- ☐ No

If Yes, please describe the reaction you had with malaria – include the medication and what you experienced.

*Are you currently taking an antibiotic?

- ☐ Yes
- ☐ No

If yes, please describe antibiotic name, does, and duration.

*Do you have significant allergies to any of the following? (Select all that apply)

- ☐ Eggs
- ☐ Gelatin
- ☐ Neomucin, Polymyxin B, Streptomycin, or Gentamicin
- ☐ Thimerosal

- ☐ Yeast
- ☐ None of the above

*Have you ever had a serious reaction to bee stings?

- ☐ Yes
- ☐ No

*Have you received any immunizations within the last 4 weeks?

- ☐ Yes
- ☐ No

If Yes, please describe the immunizations you have received within the last 4 weeks, with dates.

Describe your reaction to the vaccine.

Please indicate if there are any concerns or special conditions that you would like to discuss with the Travel Specialist?

Please list any vaccine you are looking to receive during this visit.

Please bring copies of your vaccine records to your visit or attach below if possible.

Periodically the Travel and Immunization Service participates in research or quality improvement on travel medicine issues. Please indicate if you wish to opt out of such project.

- ☐ I wish to OPT OUT – do not contact me for research or quality improvement projects.

*I agree to bring all vaccine records with me to my travel clinic, including childhood vaccination records, vaccine records from previous travel, yellow cards, COVID cards, and any other documentation of vaccinations.

- ☐ I Agree

*I agree to present to the clinic at least 15 minutes prior to my appointment time to check in and record my vaccinations.

- ☐ I Agree

*I understand that failure to produce vaccine records and/or late arrivals may result in cancellation or delay of the travel services. Delay/rescheduling could impact my ability to receive appropriate care in advance of my trip.

- ☐ I Agree