

Hammond Health Center – Ithaca College
953 Danby Road, Ithaca, NY 14850
Phone - (607) 274-3177 Fax (607) 274-1844

PRE TRAVEL PATIENT QUESTIONNAIRE

Name: _____ Date: _____
ID# _____ DOB: _____ Phone: _____

TRAVEL SPECIFICS

Purpose of Trip: School Related Study/Work What school? _____
 Pleasure Business Other: _____

What will you be doing on this trip? _____

Does your program require the completion of a medical form by a practitioner? Yes No
Departure Date from United States: _____ Return Date to United States: _____

Countries AND cities to be visited in order of visits	Arrival Date	Departure Date

A. Have you traveled outside the United States before? Yes No
If yes, where and when? _____

- B. Will you be: Yes No
- Visiting **ONLY** urban areas? If no, explain _____
 - Staying **ONLY** in Hotels? If no explain _____
 - Visiting friends and family?
 - Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains?
 - Working in the medical or dental field with exposure to blood or other body fluids?
 - Working with exposure to animals?
 - Potentially having sexual contact with new partners?

ALLERGIES

1. No known drug allergies No known food allergies
2. Have you had an allergic reaction to any of the following? (please check all that apply)
 - Eggs Quinines (Chloroquine [Aralen], Mefloquine [Lariam]
Hydroxychloroquine [Plaquenil], Primaquine)
 - Sulfa Drugs (e.g. Bactrim, Septra, Gantrisin) Pyrimethamine
 - Antibiotics (e.g. Neomycin, Streptomycin) Tetracyclines (Doxycycline, Minocin, Minocyclin,
Acromycin, Sumycin)
 - Thimerosal (preservative in contact lens solution) Other: _____
 - Chrysanthemums
 - Bee or other insect stings

Have you had any other vaccines (other than routine childhood vaccines)? YES/NO

-if yes, list what and when: (please bring record with you to appt):

Vaccine:	Date:
Tetanus/diphtheria	_____
Yellow fever	_____
Cholera	_____
Typhoid (oral or injectable)	_____
Meningococcal	_____
Polio (IPV)	_____
Hepatitis A	_____
Hepatitis B	_____
Rabies	_____
Japanese encephalitis	_____

Have you ever taken medication for malaria prevention or treatment? Yes No

Have you ever had any adverse effects from vaccines or malaria medication? Yes No

-if yes, what vaccines or medication and describe adverse effect? _____

Have you ever had a positive PPD test for tuberculosis? Yes No

Do you have psoriasis? Yes No

Do you have a history of emotional illness (such as depression, anxiety, or psychosis)? Yes No

Do you have a history of neurologic illness (such as multiple sclerosis)? Yes No

Have you ever had a seizure? Yes No

Do you take any medications for your stomach (such as antacids, ranitidine, or Prilosec)? Yes No

Do you take oral steroids (such as prednisone)? Yes No

Are you currently being treated for cancer? Yes No

Do you have a deficiency of your immune system? Yes No

Do you have a history of jaundice or hepatitis? Yes No

Do you have a history of retinal or visual problems? Yes No

Are there any immune-suppressed persons living in your household? Yes No

Are you pregnant, or do you plan to try to get pregnant in the next 3-6 months? Yes No

Are you breastfeeding? Yes No

Do you have any existing medical conditions (such as diabetes, heart disease or asthma)? Yes No

-if yes, describe: _____

Have you had any serious illnesses or hospitalizations in the last three years? Yes No

-if yes, please describe: _____

Do you have any disabilities that will require special arrangements while traveling? Yes No

-if yes, please describe: _____

Do you take any medications regularly (including birth control pills)? Yes No

-if yes, please list: _____

Do you use any herbal medicines or over the counter medicines regularly? Yes No

-if yes, please describe: _____

Do you have any special questions or concerns to address during your visit? Yes No

-if yes, please describe: _____
