Concentra Medical Centers
1234 Street Address
City, State Zip
Phone: (123) 456-7890 Fax: (123) 456-7890

Travel Health Questionnaire

Patient Name:________________________________ Date of Birth: ___________ Patient Phone Number: _____________________

Travel Information

Date leaving the United States: __________________ Duration of travel (days):________

Itinerary: Include ANY stopover in Africa or South America

Dates:	Country:	City/State/Region:

Purpose of travel: ____

Special activities planned: ____

Please check all that apply below that best describe your trip accommodations:

- ☐ Urban
- ☐ Private home
- ☐ First-class hotel
- ☐ Hostels
- ☐ Rural
- ☐ Camping
- ☐ Other hotels
- ☐ Other: ______________________________

Personal Medical History

Circle Y or N to indicate yes or no.

Y	N	Immunosuppression (HIV/AIDS, chemotherapy, radiation, recent steroids treatment, no spleen)	Y	N	Thymus disorder (Myasthenia Gravis, DiGeorge Syndrome, surgery)
Y	N	Depression, anxiety, other psychiatric disorders	Y	N	Anemia (including sickle cell)
Y	N	Cancer, Leukemia, Lymphoma	Y	N	Diabetes
Y	N	Medications/Injections that decrease immunity	Y	N	Bleeding/clotting problems
Y	N	Ear/Eye Problems	Y	N	Seizures, Multiple Sclerosis or Guillain-Barre
Y	N	Heart (including abnormal rhythm)	Y	N	Skin conditions, psoriasis, eczema
Y	N	Lung (asthma, emphysema, other)	Y	N	Fainting with injections/blood drawn
Y	N	Hepatitis, liver disease	Y	N	Altitude sickness
Y	N	Received blood, plasma or immune globulin in past 3 months	Y	N	Gastrointestinal Problems (Crohns, ulcerative colitis, ulcers, reflux, other)
Y	N	Sick/fever or antibiotics in past 7 days	Y	N	Insomnia or experience nightmares
Y	N	Kidney disease	Y	N	Tuberculosis or tested positive for TB
Y	N	Women: nursing, pregnant, planning pregnancy			Women: Date of Last Menstrual Period

Please explain marked answers above and include other medical problems and prior surgeries:

____

____

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Are you allergic to or have experienced significant side effects from any of the following?

- ☐ Antibiotics ☐ Insect bites ☐ Mercury/thimerosal
- ☐ Vaccines ☐ Eggs ☐ Other: ______
- ☐ Seafood ☐ Latex ☐ I have no known allergies

Explain all checked: ______

______

List all current medications including non-prescription and supplements: ______

______

Vaccination History

Have you ever had any of the following vaccinations? If so, when? Please bring a copy of your vaccine record and/or yellow card to your appointment.

Vaccine	Date:	Date:	Date:
COVID-19 Vaccine Manufacturer:	#1	#2	Had disease:
Varicella (Chicken Pox)	#1	#2	Had disease:
Hepatitis B/Twinrix/HeplisavB	#1	#2	#3
Hepatitis A	#1	#2	
MMR	#1	#2	
Tetanus (Td/Tdap)	Booster		
Influenza			
Polio			
Typhoid			
Rabies			
Meningococcal			
Yellow Fever			
Other			
None			

Did you complete all routine/required childhood vaccines? Yes ☐ No ☐

Have you been on anti-malaria medication? Yes ☐ No ☐ If yes, which one? ______

If yes, did you have any adverse side effects? Yes ☐ No ☐

The information above is accurate to the best of my knowledge.

Patient Signature: ______ Printed Name: ______ Date: ______

Clinician Signature: ______ Printed Name: ______ Date: ______

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