



Robert L Dobrow, MD

Certificate in Travel Health®
International Society of Travel Medicine

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Travel Health Questionnaire

Name: _____ **DOB:** _____
Last First Middle

Email: _____ **Phone:** _____

Travel Itinerary, Travel Destination, & Travel Dates:

Do your travel plans include any of the following activities?

Hiking / Trekking	Y / N	Potential Sexual Contacts	Y / N
Camping	Y / N	Piercing/Tattooing	Y / N
Swimming	Y / N	Rural Destinations	Y / N
Boating / Yachting / Cruising	Y / N	Farm or Safari Destinations	Y / N
Scuba Diving	Y / N	Contact with animals	Y / N
High Altitude Destinations	Y / N	Visiting Friends & Relatives	Y / N

Have you ever experienced any of the following travel-related conditions?

High Altitude Illness	Y / N	Other Travel-Related Illness?	Y / N
Travelers' Diarrhea	Y / N	Please list:	_____
Travel-Related Edema	Y / N		_____
Travel-Related Insomnia	Y / N		_____

Have you ever experienced any of the following travel-related conditions?

- | | | | |
|----------------------|-------|--------------------------|-------|
| Asthma | Y / N | Diabetes | Y / N |
| Arthritis | Y / N | Edema | Y / N |
| Blood Clots | Y / N | Heart Disease | Y / N |
| Cancer | Y / N | HIV/AIDS | Y / N |
| Chronic Lung Disease | Y / N | Immune Suppression | Y / N |
| Coumadin Therapy | Y / N | Musculoskeletal Injuries | Y / N |
| Depression / Anxiety | Y / N | Thymus Disorder | Y / N |
| | | Tuberculosis | Y / N |

Please list all your medical conditions:

Please list all your medications, including over the counter medications, vitamins, supplements and herbs:

Do you take medications that suppress your immune system such as prednisone, chemotherapy drugs, or drugs for rheumatoid arthritis and other autoimmune diseases? Y / N

Are you pregnant or planning to become pregnant while traveling? Y / N

Are you breast-feeding? Y / N

Are you ALLERGIC to any medications?

If yes, please list: _____

Are you ALLERGIC to:

- | | | | |
|------------|-------|----------|-------|
| Eggs | Y / N | Latex | Y / N |
| Yeast | Y / N | Mercury | Y / N |
| Thimerosal | Y / N | Vaccines | Y / N |

If you have a Vaccination Record, please forward or bring a copy.

Have you received any vaccinations in the last 4 weeks? **Y / N**

Are you allergic to any vaccines? **Y / N**

Have you received any of the following vaccines, if so when?

	Dates:
Chicken pox Y / N	_____
Hepatitis A Y / N	_____
Hepatitis B Y / N	_____
Human Papillomavirus (HPV) Y / N	_____
Influenza Y / N	_____
Japanese Encephalitis Y / N	_____
Measles, mumps, rubella Y / N	_____
Meningococcal Y / N	_____
Pneumococcal Y / N	_____
Polio Y / N	_____
Rabies Y / N	_____
Shingles Y / N	_____
Tetanus & Diphtheria Y / N	_____
Tetanus, Diphtheria & Pertussis Y / N	_____
Typhoid Y / N	_____
Yellow Fever Y / N	_____

Signed: _____ **Date:** _____