PIVOT
OCCUPATIONAL HEALTH

TRAVEL MEDICINE HISTORY QUESTIONNAIRE

Date:

Patient Name:

DOB:

Place of Birth: _____

Have you ever traveled or worked outside the Continental USA ( ) No ( ) Yes
If Yes, Please describe: _____

Referred by: _____

Departure Date: _____ Return date: _____

Purpose of Travel (check one)

( ) Business ( ) Vacation ( ) Field Work ( ) Missionary ( ) Teacher ( ) Climbing ( ) Diving
( ) Foreign Study ( ) Volunteer Agency _____
( ) Other: _____

Type of Travel (check choices)

( ) Guided or escorted tour
( ) Independent travel: fixed itinerary
( ) Independent travel: flexible itinerary

( ) Other: _____

Accommodations (check choices)

( ) Hotel ( ) Resort ( ) Private Home ( ) Safari ( ) Camp ( ) Youth Hostel ( ) Rented foreign home

( ) other: _____

Itinerary

Country	Duration	Rural	Urban	List Name of City

Past International Travel

Country	Year	Country	Year

PIVOT OCCUPATIONAL HEALTH

Patient name:

Prior Immunizations (with dates)

NO	Yes	Date	Immunization	NO	Yes	Date	Immunization
( )	( )	_____	Diphtheria/tetanus	( )	( )	_____	Plague
( )	( )	_____	Hepatitis A	( )	( )	_____	Polio (injection)
( )	( )	_____	Hepatitis B	( )	( )	_____	Polio (oral)
( )	( )	_____	Japanese Encephalitis	( )	( )	_____	Polio Booster
( )	( )	_____	Measles	( )	( )	_____	Rabies
( )	( )	_____	Mumps	( )	( )	_____	Typhoid
( )	( )	_____	Rubella	( )	( )	_____	Yellow Fever
( )	( )	_____	Meningococcal Vaccine	( )	( )	_____	Cholera
( )	( )	_____	HIB	( )	( )	_____	DPT
( )	( )	_____	Influenza	( )	( )	_____	Varicella
( )	( )	_____	IGG	( )	( )	_____	Pneumococci
( )	( )	_____	Other _____				

Did you have any adverse reaction to any of the above? ( ) No ( ) Yes
If yes, please describe: _____

If you were **born after 1957**, have you had measles? ( ) No ( ) Yes

If not have you been immunized against measles since 1980? ( ) NO ( ) Yes

Allergies (Medication, Food, Environmental factors)
_____

Current Medical Conditions: _____

Do you have a history of any of the following?

( ) No	( ) Yes	Psoriasis	( ) No	( ) Yes	Seizure disorder / epilepsy
( ) No	( ) Yes	Hepatitis	( ) No	( ) Yes	Heart rhythm problems
( ) No	( ) Yes	Depression	( ) No	( ) Yes	other psychiatric disorder
( ) No	( ) Yes	Bleeding or coagulation disorder			

Are you currently taking any medications (including over-the-counter drugs)? ( ) No ( ) Yes
If yes, please list: _____
_____

Do you take any of the following medications?

( ) No	( ) Yes	Beta Blockers (e.g. Inderal)	( ) No	( ) Yes	Quinidine
( ) No	( ) Yes	Calcium channel blockers (e.g. Verapamil)	( ) No	( ) Yes	Quinine
( ) No	( ) Yes	Any other heart medications	If yes, please list: _____		
( ) No	( ) Yes	Anti-seizure medications	If yes, please list: _____		

For females: Date of last menstrual cycle _____

Are you pregnant or/your partner considering trying to become pregnant during your stay abroad? ( ) No ( ) Yes
Are you at risk for immune deficiency? ( ) No ( ) Yes

Traveler's Signature: _____

Reviewed by: _____