

LONG ISLAND TRAVEL MEDICINE
Long Island Infectious Disease Associates
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Travel Questionnaire

Name _____ **Date of Birth** ____/____/____

Referring Physician _____ telephone # _____

Referring Business Name (if applicable) _____

Date of Departure ____/____/____ **Date of Return** ____/____/____

Destination – countries and areas within countries, for example, rural vs. urban

Accommodation during Travel _____

Do you have or had any?

- heart murmur, rheumatic fever, congenital heart lesions
- heart disease, hypertension, heart failure, angina
- artificial heart valve, heart pacemaker, heart surgery
- respiratory disease, emphysema, tuberculosis, asthma, hay fever
- liver disease, hepatitis, jaundice
- drug addiction, alcoholism
- epilepsy fainting or dizzy spells, nervousness, psychiatric treatment
- bruise easily, bleeding problems
- active cancer, leukemia, lymphoma or immune deficiency disease
- HIV disease or AIDS
- receiving cancer chemotherapy, immunosuppressive therapy, radiation therapy, prednisone
- are or may be pregnant now or may become pregnant before or during your trip
- has your spleen been removed
- are you taking antibiotics now?
- Previous travel-related illnesses (please explain): _____

Do you take any medications? (list): _____

Have you received immunoglobulin, a blood transfusion or other blood product within the last three months? () yes () no

Allergies:

- () have had allergic reaction to eggs (can't eat eggs)
- () known allergy to thimerosal (a mercury derivative)
- () have fainted after shots
- () allergic reaction to any vaccines
- () allergy to any medications (list): _____

Immunization History:

	Yes	No	Last dose/booster date
Yellow fever	()	()	
Oral polio	()	()	
Injectable polio	()	()	
Hepatitis A	()	()	
Hepatitis B	()	()	
Meningococcal	()	()	
Measles or MMR	()	()	
Rubella	()	()	
Oral typhoid	()	()	
Tetanus/diphtheria	()	()	
Pneumococcal	()	()	
Japanese encephalitis	()	()	
Influenza vaccine	()	()	
Other:			

Please check if any of these situations apply to you?

- () Born after 1956 and had fewer than two doses of measles or MMR vaccine
- () expect prolonged/close contact with unprivileged local populace in a developing nation
- () expect poor food and water sanitation conditions
- () anticipate HEAVY mosquito exposure

The above information is complete and accurate. I request and consent to the administration of the vaccines to myself (or to the patient if I am the parent or guardian) agreed upon by myself and the doctor.

Name

Date: