Hutchinson Health Clinic
3 Century Avenue
Hutchinson MN 55350
(320) 587-2020
(800) 944-2690
www.HutchHealth.com

International Travel Medical Questionnaire

Please fill out this form & bring it with you to your Travel Clinic Appointment and bring all current medication to your appointment. Also bring any immunization records you may have.

Name:_____DOB:_____ Male or Female

Address:_____ Social Security:_____

Home phone _____ Work phone_____

Primary Clinic _____ Primary Provider_____

Itinerary:_____ Rural or Urban or Both

Date:_____Date of Departure:_____ Length of Stay_____

Immunizations	**Yes**	**No**	**Problem****
Have you ever fainted from having your blood drawn or from an injection?			
Have you ever had a fever reaction to vaccination?			DTaP, Td
Have you ever had *any* bad reaction or side effect from any vaccination?			
Have you every had hepatitis A or B vaccine?			
Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder or who is on chemotherapy for cancer?			Varicella, Smallpox, Influenza (FluMist™)
Do you have a family history of immunodeficiency?			Varicella, Smallpox
Have you received any injection of immune globulin or any blood product during the past 12 months?			Varicella, Measles-containing vaccine, Smallpox

General Medical	**Yes**	**No**	**Problem****
Do you have a medical condition that warrants maintenance medications or physician follow-up?			
Do you have a medical condition that is stable now, but that may recur while traveling?			
Have you had a fever in the past 48 hours?			Td, Influenza, Meningococcal, Oral typhoid, Pneumococcal (PPV)
Are you pregnant* or might become pregnant on this trip?			MMR or components, Oral typhoid, Smallpox, Varicella, Yellow Fever, Influenza (Flumist™), Oral Cholera (Muracol ®); Doxycycline and other antibiotics. For other immunizations weigh the theoretical risk of vaccination against the risk of disease.
Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia or cancer?			MR or components, Oral Typhoid, Smallpox, Rabies, Varicella, Yellow Fever, Oral Cholera (Muracol ®), Influenza (FluMist™)
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?			any intramuscular injection
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?			Mefloquine, DTaP
Do you have any stomach conditions?			Oral typhoid, Mefloquine, Doxycycline
Do you have a G6PD deficiency?			Chloroquine, Primaquine
Do you have bowel conditions such a diarrhea or constipation?			
Have you ever had hepatitis or yellow jaundice?			
Do you have a history of psychiatric problems?			Mefloquine
Do you have a problem with strange dream and/or nightmares?			Mefloquine
Do you have insomnia?			Mefloquine
Do you have problems with vaginitis?			any antibiotic
Do you have psoriasis?			Chloroquine or related compounds
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis (e.g., itchy, red, scaly rash lasting > 2 weeks that often comes and goes)?			Smallpox
Cardiac disease, with or without symptoms?			Smallpox, Influenza (FluMist™)

Name: DOB: DATE:

Do you have any eye conditions?			
Are you prone to motion sickness?			

Medications	**Yes**	**No**	**Problem****
Are you taking or will you be taking:			
Quinine, quinidine, or medications for a cardiac conduction defect?			Mefloquine
Chloroquine, mefloquine, or proguarill to prevent malaria?			Oral Thypoid, Oral Cholera (Mutacol®) MMR or components, Oral Typhoid, Varicella, Yellow Fever, Influenza (FluMist™)
Antibiotics?			Oral Typhoid, Oral Cholera (Muracol®)
Pepto-Bismol® to prevent traveler's diarrhea?			Doxycycline, Tetracycline
Antacids?			Doxycycline, Tetracycline
Oral contraceptives?			Doxycycline, Tetracycline
Aspirin therapy? (children & adolescents)			Varicella, Influenza (FluMist™)
Medications for emotional problems?			Mefloquine
Medication for convulsions?			Mefloquine

Allergies	**Yes**	**No**	**Problem****
Are you allergic to:			
Any medications?			
Amphotericin B?			Rabies (PCEC)
Penicillin or sulfa?			Diamox®, Fansidar®, Penicillin, Sulfa
Mercury or thimerosal?			DTaP (Tripedia®), DT, Td, Hib (TriHIBit™, HibTITER® multidose), Japanese Encephalitis, Hepatitis b, Hep. A/B (Twinrix®), IG, Influenza, Meningococcal (multidose), Rabies (RVA, RIG), Tetanus IG (Hyper-Tet®)
Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)			Hepatitis A/B (Twinrix®), Influenze, IPV, MMR or components, Rabies [HDCV and PCEC], Varicella, Smallpox, PEDIARIX™
Polymyxin?			Influenza (Fluvirin®), IPV, Smallpox, PEDIARIX™
Sulfites?			Influenza (Flogen®), Doxycycline
Aluminum or aluminum hydroxide			Hep A, Hep B, Hep A/B (Twinrix®), COMVAX™, DTaP, Td, Rabies (RVA), Anthrax, Pneumoccoccal (PVC), Oral Cholera (Dukoral™)
Benzethonium chloride?			Anthrax
2-phenoxyethanol?			Hep A (Havrix ®), Hep A/B(Twinrix®), IPV, DTaP, (Infanrix™, PEDIARIX™)
Bee stings or history of hives or urticaria?			Japanese Encephalitis
Yeast?			Hep B, Hep A/B (Twinrix®), PEDIARIX™, Oral Cholera (Mutacol®)
Eggs?			Influenza, Rabies (PCEC), Yellow Fever, MMR or components
Glycerin or chlortetracycline?			Smallpox
Are you hypersensitive to gelatin?			Varicella, Japanese Encephalitis, MMR or components, DTaP, Yellow Fever, Rabies (PCEC), Influenza (Fluzone), Oral Typhoid
Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formaldehyde?			IPV, Meningococcal, Typhoid, Rabies, DTaP, Pneumococcal (PPV), Anthrax, Smallpox

**Note: Any "problem" listed above may be a contraindication or merely a precaution that warrants further discussion between the health care provider and patient. The "problem" list is not all-inclusive but is representative of common issues that arise in a pre-travel consultation.

SIGNATURES: _____ _____

(Traveler and date) (Health Care Provider and date)

Name: DOB: Date:

Please note below any diseases you have had, with dates if possible.

Disease name	Had disease – list date if possible
Measles (rubeola)	
Mumps	
Rubella (German measles)	
Chicken Pox (varicella)	

Please record the dates you received any of the following Immunizations
(You may have to check with previous health care providers to get all of this information.)

ROUTINE IMMUNIZATIONS	**Date**	**Date**	**Date**	**Date**
Diphtheria-Tetanus (Td or DT)				
Diphtheria-Tetanus-Pertussis (DTaP)				
DTaP/Hib				
H. Influenza type b (Hib)				
Hepatitis B				
Hepatitis B/Hib (combination)				
Influenza				
Measles (Monovalent)				
Measles, Mumps and Rubella (MMR)				
Pneumococcal: Conjugate (PCV)				
Pneumococcal: Polysaccharide (PPV23)				
Polio: Injectable (IPV)				
Polio: Oral (OPV)				
PPD				
Varicella				
OTHER IMMUNIZATIONS	**Date**	**Date**	**Date**	**Date**
Yellow Fever				
Cholera				
Hepatitis A				
Hepatitis A/B (combination)				
Immune Globulin (IG)				
Japanese Encephalitis				
Lyme Disease				
Meningococcal				
Rabies: Intradermal				
Rabies: Intramuscular				
Typhoid: Oral				
Typhoid: Injectable - Typhim Vi				

Have you taken medication in past for Malaria: Y N
Side effects?_____

Please list any **existing medical conditions**: (example: diabetes, heart disease, or lung disease) _____
_____
_____

List all medications you currently are taking, either prescriptions or over-the-counter: _____
_____

List any Allergies you have: _____

Are you pregnant or might you become pregnant on this trip? Yes / No

If pregnant, how many weeks?_____

Are you breast feeding? Yes / No

Are you prone to motion sickness? Yes / N**o**

Name:	DOB:		Date:		
Immunizations/Vaccinations	Required	Recommended	Provider Init	Pt Refused	Dates Due
Diphtheria, Tetanus, Pertussis (DTaP/DTP) if <7 yrs of age					
Hepatitis A					
Hepatitis B					
Hepatitis A/Hepatitis B combined					
H. Influenza type b (Hib)					
Hib/DTaP or Hib/DTP					
Hib/Hepatitis B					
Influenza					
Japanese encephalitis					
Measles, Mumps, Rubella					
Meningoccal Meningitis					
Pneumococcal conjugate (PVC)					
Pneumococcal Polysaccharide (PPV23)					
Poliomyelitis, primary series					
Polio booster					
Rabies (vaccine or IG)					
Tetanus, Diphtheria (Td) if >7 yrs of age					
Typhoid fever					
Varicella (chicken pox)					
Yellow Fever					
Other:					

Prophylactic Medication			
Indication	**Required**	**Recommended**	**Medication/Rx given**
Malaria			
Anti diarrhea			
Anti nausea			

Provider Signature:_____**Date:**_____

Patient Consent: I have read the written information given to me and I have discussed with my doctor and/or nurse the benefits and risks of the vaccines noted above which are required and/or recommended for my protection while traveling abroad. I have had a chance to ask questions which were answered to my satisfaction. I request that these vaccines be given to me or to the person named below for whom I am authorized to make this request. I hereby authorize and request you to furnish this record to:_____.

Relationship to patient_____Signature_____Date:_____

Witness_____

Minor surgery complete/review with provider/provider signature for order/file in chart/copy to patient by minor surgery nurse

Name: DOB: Date:

Teaching: (date done) _____ ____ **Done previously** ____ **Brief review**

Handouts given to the patient – check all that apply:

- ❑ Travelers Medical Record
- ❑ Trip Kit Checklist
- ❑ Country handouts from Travex
- ❑ Traveler education (which includes)

✓Health Care Abroad
✓Safety and security
✓Altitude illness
✓Beaches and swimming
✓Cold
✓Heat and Sun
✓Air travel/jet lag
✓Water precautions
✓Food precautions
✓Travelers Diarrhea
✓Protecting yourself from insects
✓Bites and Stings
✓Sexual contact

Other handouts given to the patient

❑Children and travel
❑Diabetic Travelers
❑Disabled Travelers
❑Pregnancy Travelers
❑Diving
❑Marine Environment
❑Heart Disease and Travel
❑HIV or AIDS infected Travelers
❑Ly me Disease and Babesiosis
❑Pulmonary Disease and Travel
❑Stomach Disorders and Travel
❑Motion sickness
❑Malaria Rx information

Vaccine information sheets:

❑Cholera
❑Flu
❑Hepatitis A
❑Hepatitis B
❑ IG
❑Pertussis
❑J. encephalitis
❑Measles
❑Meningococcal
❑MMR
❑Oral typhoid
❑Pneumococcal
❑Polio
❑Rabies
❑Td
❑Typhoid
❑Yellow fever

Work-up prepared by_____