



## PRE-TRAVEL EVALUATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you ever traveled internationally before?  Yes  No

Where will you be traveling this trip?

City/Country/Province: \_\_\_\_\_ Number of Days (approx): \_\_\_\_\_

City/Country/Province: \_\_\_\_\_ Number of Days (approx): \_\_\_\_\_

City/Country/Province: \_\_\_\_\_ Number of Days (approx): \_\_\_\_\_

Other locations (including airport layovers): \_\_\_\_\_

What is the primary purpose of your trip (check all that apply)?

Business  Leisure  Visit Family  Religious  Other: \_\_\_\_\_

Where do you anticipate spending your evenings?

Hotel/AirBnB  Family/Friends House  Outdoor (tent/cabin)  Boat or Cruise Ship  
 Other: \_\_\_\_\_

What recreational activities might you engage in while on your trip?

Adventure/extreme sports  Relief work/Mission trip  
 Contact with animals  Sex with locals  
 Eating local/street food  Sun exposure (prolonged)  
 Outdoor excursions  Swimming/Beach/Open water

Do you have, or have you had, any of the following conditions that might affect your travel?

Altitude sickness  Seasonal allergies  
 Insomnia  Sleep apnea/Use CPAP  
 Motion sickness  Traveler's diarrhea

### Details

Are you pregnant or might you become pregnant during this trip?  Yes  No \_\_\_\_\_

Have you had surgery in the last 30 days?  Yes  No \_\_\_\_\_

Have you ever had skin cancer?  Yes  No \_\_\_\_\_

Are you allergic to bees or other insects?  Yes  No \_\_\_\_\_

How much do you use/do the following?

Alcohol:  None  Rare  Occasional  Regularly

Tobacco:  None  Rare  Occasional  Regularly

Recreational drugs:  None  Rare  Occasional  Regularly

Exercise:  None  Rare  Occasional  Regularly

**CURRENT MEDICAL CONDITIONS**

Do you have any of the following chronic medical conditions that might affect your travel or travel preparedness?

**Blood disorders**

I have no known blood disorder

Clot/DVT/Pulmonary Embolism     Easy Bleeding     Easy Bruising     Sickle Cell Anemia

Other: \_\_\_\_\_

**Lung disease**

I have no known lung disease

Asthma     Bronchitis     COPD     Cystic Fibrosis     Lung Cancer     Sarcoidosis

Other: \_\_\_\_\_

**Heart disease**

I have no known heart disease

Congenital heart disease     Congestive heart failure     Coronary disease     Pacemaker/Defibrillator

Other: \_\_\_\_\_

**Immune system abnormalities**

I have no known immune system abnormality

Chronic immunosuppressive medications     Immunodeficiency disease     Stem cell transplant

Other: \_\_\_\_\_

**Infectious diseases**

I have no known infectious disease

Hepatitis B     Hepatitis C     HIV     Tuberculosis

Other: \_\_\_\_\_

**Neurologic disease**

I have no known neurologic disease

Guillain-Barre Syndrome     Seizures

Other: \_\_\_\_\_

Do you have any other major medical conditions that might affect your travel?     Yes     No

If YES, please describe: \_\_\_\_\_

**CURRENT MEDICATIONS**

Do you take Coumadin (warfarin)?     Yes     No

Do you regularly take a sleep aid?     Yes     No

Do you regularly take antibiotics?     Yes     No

Are you taking prednisone or other immunosuppressive medications?     Yes     No

Are you allergic to any medications?     Yes     No

If YES, which medications: \_\_\_\_\_

**VACCINE ADVERSE EFFECTS**

Have you ever passed out after receiving a vaccine?     Yes     No

Have you ever had a severe reaction to a vaccine?     Yes     No

If so, which vaccine(s):

Vaccine: \_\_\_\_\_ Reaction: \_\_\_\_\_

Vaccine: \_\_\_\_\_ Reaction: \_\_\_\_\_