Travel Medicine Clinic
Harbourside Family Practice

Traveler Questionnaire

1. Name: _____ DOB: _____

2. Purpose of Travel: _____ Departure Date: _____

3. Please list in order the countries you intend to visit and how long you will stay in each:

Country	Cities	Arrival Date	Length of Stay	Type of Accomodation

4. Have you been immunized against any of the following? If yes, please write the date received. We recommend you also bring your immunization records with you to your appointment.

Vaccine	Yes	No	Date	Comments
Polio				
Tetanus/diptheria/ pertussis				
Measles/mumps/rubella				
Hepatitis A				
Hepatitis B				
Typhoid oral/injection (circle one)				
Yellow Fever				
Japanese Encephalitis				
Rabies				
Meningitis				
Influenza				
Varicella				
Other				

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5. Do you have a history of allergies to any of the following: chickens, eggs, insect bites, sulfa drugs, or other medications? (circle) If yes, please describe: _____

_____

6. Are you pregnant? Yes / No If Yes, due date: _____

7. Do you have any medical problems or chronic illnesses? If yes, please describe: _____

_____

-_____

8. Please list any medications you are currently taking: (please include prescriptions, over the counter, vitamins, supplements etc.) _____

_____