Travel Medicine Clinic
Harbourside Familiy Practice

Traveler Questionnaire

1. Purpose of travel: _____ Date of Departure:_____
2. 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 Accommodation

3. Have you been immunized against any of the following? If yes, please write the date received.

Vaccine	Yes	No	Date	Had Disease/ How/When Diagnosed
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:				

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

5. Are you pregnant? Yes / No If yes, due date: _____
6. Do you have any medical problems? If yes, please describe: _____
_____
_____

8. Please list any medications (prescription, over the counter, herbal meds, vitamins) that you are currently taking:
_____