Division of Infectious Diseases

Columbia University Medical Center

Pre-Travel Questionnaire

Prior to your appointment, please complete and submit this form to:

Travel Medicine- Columbia University Infectious Disease Associates

Fax: 212-305-1754

Email: infectious_diseases@columbia.edu

Standard Mail: Infectious Disease Associates
161 Fort Washington Avenue
IP 2-215
New York, New York 10032

Name: Last _____ First _____ **DOB: ___ / ___ / _____**

1a. What are your departure and return dates?

Departure: ___ / ___ / _____

Return: ___ / ___ / _____

1b. Where and when will you be traveling?

Country	Date In	Date Out
1. _____	___ / ___ / _____	___ / ___ / _____
2. _____	___ / ___ / _____	___ / ___ / _____
3. _____	___ / ___ / _____	___ / ___ / _____
4. _____	___ / ___ / _____	___ / ___ / _____

2a. Are you allergic to any of these medications?

	No	Yes	Don't know	
Tetracycline or Doxycycline	[ ]	[ ]	[ ]	
Chloroquine / Mefloquine		[ ]	[ ]	[ ]
Malarone (atovaquone/proguanil)		[ ]	[ ]	[ ]
Ciprofloxacin	[ ]	[ ]	[ ]	

2b. In the space below, please write down any medications to which you are allergic:

2c. In the space below, please write down any medications which you are currently taking:

3. Have you ever received any of these vaccines/immunizations?

	No	Yes	If yes, what year?
Typhoid vaccine		[ ]	[ ] _____
Yellow fever vaccine	[ ]	[ ]	_____
Hepatitis A vaccine	[ ]	[ ]	_____
Hepatitis B vaccine	[ ]	[ ]	_____
Meningococcal vaccine	[ ]	[ ]	_____
Japanese encephalitis vaccine	[ ]	[ ]	_____
Rabies vaccine	[ ]	[ ]	_____
Cholera vaccine	[ ]	[ ]	_____

4. Have you ever received a booster to any of these vaccines/immunizations?

	No	Yes	If yes, what year was the last booster?
Polio booster	[ ]	[ ]	_____
Tetanus booster		[ ]	[ ] _____
Pertussis booster		[ ]	[ ] _____