BCM Travel Medicine
Baylor Clinic
6620 Main Street
13th Floor, Suite 1375
Houston, Texas 77030
Phone: 713.798.TRVL (8785)
Fax: 713.798.0171

Pre-Travel Questionnaire

Allow us to optimize your care by returning this completed form as soon as possible!
Please e-mail your form to travelquestionnaire@bcm.edu or fax to 713-798-0171.
Delay in returning the form may result in delays in your receipt of the appropriate immunizations for your trip.

Personal Information

1. Patient name: _____ Patient date of birth: _____
2. Pharmacy name: _____ Pharmacy phone: _____

Travel Information

3. What is the purpose of your travel? (Check all that apply)
   - ☐ Business ☐ Relocation ☐ Missionary/Volunteer work ☐ Medical Care
   - ☐ Vacation ☐ Teaching/Study ☐ Visiting friends/relatives ☐ Adoption
   - ☐ Other _____

4. What activities do you have planned? (Check all that apply)
   - ☐ Hiking ☐ Biking ☐ Climbing ☐ Spelunking
   - ☐ Snorkeling ☐ Scuba diving ☐ Rafting ☐ Safari
   - ☐ Other _____

5. Where will you be staying? (Check all that apply)
   - ☐ Hotel/Resort ☐ Camp/Tent ☐ Rented home ☐ Off-shore rig
   - ☐ Cruise ship ☐ Compound ☐ Private home (i.e., staying with locals)
   - ☐ Other _____

6. Type of Travel (Check all that apply)
   - ☐ Group/Tour ☐ Independent ☐ Fixed itinerary ☐ Flexible itinerary

7. Do you have travel insurance? (Check "Yes" or "No")

	Yes	No		Yes	No
Travel health insurance	☐	☐	Medical evacuation insurance	☐	☐

8. List your travel destinations, including airport stopovers, in order of travel.

Country	City	Arrival Date	Departure Date	Area Type
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural
				☐ Urban ☐ Rural

Immunization History

9. List the dates of your vaccines in the appropriate boxes. Otherwise, check "Had disease" or "Unknown."

	Vaccine dates #1	#2	#3	Had Disease	Unknown
Hepatitis A virus				☐	☐
Hepatitis B virus				☐	☐
Influenza				☐	☐
Japanese encephalitis				☐	☐
Measles, Mumps, Rubella (MMR)				☐	☐
Meningococcus (meningitis)				☐	☐
Pneumococcus (pneumonia)				☐	☐
Polio, injection				☐	☐
Rabies				☐	☐
Tetanus, diphtheria (Td)				☐	☐
Tetanus, diphtheria, pertussis (Tdap)				☐	☐
Typhoid, injection				☐	☐
Typhoid, oral				☐	☐
Varicella (chickenpox)				☐	☐
Yellow fever				☐	☐

10. Answer the following immunization-related questions. (Check "Yes" or "No")

	Yes	No
Do you have an "International Certificate of Vaccination or Prophylaxis"?	☐	☐
Have you ever fainted or had an adverse reaction to vaccines?	☐	☐
Have you received blood, blood products, or immune globulin in the past 12 months?	☐	☐
Have you had any immunizations in the past 30 days?	☐	☐

If yes, list: _____

Please bring to your appointment all available immunization records, including your yellow Certificate of Immunization (if you have one).

Patient name: _____ Patient date of birth: _____

Please e-mail your form to travelquestionnaire@bcm.edu or fax to 713-798-0171.

Medical History

11. Do you have the following problems/conditions? (Check "Yes" or "No")

	Yes	No		Yes	No
Strange dreams or nightmares	☐	☐	Myasthenia gravis	☐	☐
Insomnia	☐	☐	Thymoma or history of thymus removal	☐	☐
Psoriasis	☐	☐	Guillain Barre syndrome	☐	☐
G6PD deficiency	☐	☐	Seizure/Epilepsy	☐	☐
Bleeding/clotting disorder	☐	☐	Stomach/Colon problems	☐	☐
Irregular heartbeat/arrhythmia	☐	☐	Acid reflux or heartburn	☐	☐
Depression/Psychiatric disorder	☐	☐	History of altitude sickness	☐	☐
Cancer, HIV infection, or immune disorder	☐	☐	Prone to motion sickness	☐	☐
Breastfeeding	☐	☐	Seasonal or environmental allergies	☐	☐
Pregnant or planning to become pregnant within the next 3 months	☐	☐	Allergy to bee or wasp stings	☐	☐

12. Do you have any other medical problems for which you are receiving treatment? ☐ Yes ☐ No

If yes, list: _____

_____

_____

_____

13. Are you currently receiving the following therapy? (Check "Yes" or "No")

	Yes	No
Cortisone, prednisone, or other oral steroid	☐	☐
Chemotherapy or radiation therapy	☐	☐

14. Are you taking any other prescribed or over-the-counter medications? ☐ Yes ☐ No

	Medication	Dose
If yes, list:	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

15. Are you allergic to any medications? ☐ Yes ☐ No

If yes, list: _____

Patient name: _____ Patient date of birth: _____

Please e-mail your form to travelquestionnaire@bcm.edu or fax to 713-798-0171 as soon as possible.