LifeScape
Medical Associates, PC

Pre-Travel Questionnaire

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete answers or provide additional information.

DEMOGRAPHICS

Patient: _____ Last Name _____ First Name _____ Middle Initial

Sex: ☐ M ☐ F Age: _____ Date of Birth: MM / DD / YYYY Social Security No.: _____

Home Address: _____ Street _____ City _____ State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Emergency Contact: _____ Last Name _____ First Name _____ Relationship: _____

Address: _____ Street _____ City _____ State Zip Code Phone: _____

Primary Care Provider: _____ Last Name _____ First Name _____ Phone: _____

Address: _____ Street _____ City _____ State Zip Code

How did you hear about LifeScape's travel clinic? _____

TRAVEL INFORMATION

Please list all countries and areas you will be visiting in chronological order with the dates of travel:

_____ Country _____ City/Province/Area From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area From: MM / DD / YYYY To: MM / DD / YYYY

Please state the purpose of your trip (check all that apply):

☐ Business ☐ Vacation/Leisure ☐ Visiting Family/Friends ☐ Missionary
☐ Humanitarian ☐ Adventure Travel ☐ Adoption ☐ Other _____ Specify

Please state the anticipated travel conditions and activities (check all that apply):

☐ Organized Group Travel ☐ Independent Travel
☐ Hotel ☐ Cruise Ship ☐ Private Home
☐ Dormitory or Youth Hostel ☐ Camping ☐ Wilderness Areas _____ Specify
☐ Contact with Animals or Insects ☐ Providing Medical Care ☐ Doing Field Work
☐ Altitude (greater than 8,000 feet) ☐ Swimming or Diving ☐ Physical Exertion _____ Specify
☐ Other High Risk Activities _____ Specify

Have you traveled previously to developing countries? ☐ Y ☐ N _____ Specify

Do you have medical evacuation insurance? ☐ Y ☐ N

Will your medical insurance cover illness or accidents abroad? ☐ Y ☐ N

MEDICAL INFORMATION

Are you presently in good health (any fever or infection)? ☐ Y ☐ N

If No, please describe your condition: _____

_____

_____

_____

Do you have any allergies? ☐ Y ☐ N

If Yes, please list and describe type of reaction:

Medications: _____

Environmental (for example, hay fever and pollen): _____

Bee or Wasp Sting: _____

Foods: _____

Eggs or Gelatin: _____

Other: _____

If female, are you currently pregnant or do you plan to become pregnant within the next 3 months? ☐ Y ☐ N

Please list all medications you are using including vitamins, herbal supplements, and oral contraception: _____

_____

_____

_____

Please check if you have or have ever had any of these conditions or treatments:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV / AIDS
☐ Kidney Failure or Dialysis ☐ Insulin Dependent Diabetes ☐ Epilepsy or Seizures ☐ Myasthenia Gravis
☐ Digestive Tract Problems ☐ Heart Disease or Heart Attack ☐ Skin Disease ☐ Eczema
☐ Recent Surgery or Hospitalization ☐ Radiation or Chemotherapy ☐ Thymectomy ☐ Splenectomy

Do you have cancer, leukemia, lymphoma, an organ transplant, rheumatoid arthritis, Crohn's disease, or ulcerative colitis? ☐ Y ☐ N

Do you take cortisone, prednisone, or any other steroids, anti-cancer, or immunosuppressive medications?
☐ Y ☐ N

Do you live with anyone who may have a compromised immune system from any condition including cancer, leukemia, an organ transplant, or HIV / AIDS? ☐ Y ☐ N

Is anyone in your household pregnant or trying to become pregnant? ☐ Y ☐ N

Please describe any special problems you anticipate while traveling or health concerns you wish to discuss with the clinician: _____

_____

_____

IMMUNIZATIONS

Are you up to date on your childhood vaccines? ☐ Y ☐ N
Do you have an immunization record with you? ☐ Y ☐ N
Have you received any vaccinations during the past four weeks? ☐ Y ☐ N
Have you ever had a serious reaction to a vaccination? ☐ Y ☐ N
If Yes, please specify the vaccination(s) and describe the reaction(s): _____

_____

Vaccine	**Date of last immunization if applicable**
Hepatitis A 1__, 2__	MM / DD / YYYY
Hepatitis B 1__, 2__, 3__	MM / DD / YYYY
Hepatitis A&B (Twinrix) 1__, 2__, 3__, 4__	MM / DD / YYYY
Influenza (flu)	MM / DD / YYYY
MMR (Mumps, Measles, Rubella) __ or born *before* 1957 __	MM / DD / YYYY
Polio / IPV / OPV	MM / DD / YYYY
Pheumonia (Pneumovax)	MM / DD / YYYY
Typhoid oral __, injectable __	MM / DD / YYYY
Yellow Fever	MM / DD / YYYY
Japanese Encephalitis 1__, 2__, 3__	MM / DD / YYYY
Meningitis (Meningococcal)	MM / DD / YYYY
Chickenpox (Varicella) disease ____ or vaccines 1__, 2 __	MM / DD / YYYY
HPV (Gardasil) 1__, 2__, 3__	MM / DD / YYYY
Rabies 1__, 2__, 3__	MM / DD / YYYY
Tetanus / Diphtheria	MM / DD / YYYY
Gamma Globulin	MM / DD / YYYY
PPD (Tuberculin Skin Test)	MM / DD / YYYY
BCG	MM / DD / YYYY

ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information. _____

_____

_____

_____

_____

_____

_____

_____ _____
Signature of the Patient or the Patient's Legal Representative Date

_____ _____
Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient