Travel Health Assessment

Name _____ Date of Birth ___/___/____

Destination _____ Departure Date ___/___/___ Length of stay _____

Reason for Travel: ____ Pleasure ____ Business ____ Mission ____ Other

_____

Health questions: **Circle:**

1. Are you well today? yes no unsure

2. Have you had any vaccines in the past month? yes no unsure

If YES what:_____

Please check the boxes if you have had any of the following conditions?

☐ Heart problems	☐ High Blood pressure	☐ Problems with Immune system	☐ Stomach problems	
☐ Diabetes	☐ Kidney disease	☐ Cancer	☐ Liver Disease	
☐ Lymphoma	☐ HIV/AIDS	☐ Lung disease	☐ Leukemia	
☐ Eye condition	☐ Psoriasis	☐ Arthritis	☐ Blood disorder	

3. Have you ever had a serious reaction to a vaccine or a fainting spell? yes no unsure

4. Have you had a seizure or brain or nervous system problem? yes no unsure

5. Do you have allergies to: (circle) medications, foods? vaccine component or latex? yes no unsure

List :_____

6. In the past 3 months have you taken medications that may have weaken your immune system, such as Humera, cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments? yes no unsure

7. **Women:** Are you pregnant or chance you may become pregnant? yes no unsure

Please list any current medications:	Are you taking antibiotics now or recently? ___yes ___no Are you taking heart medication i.e. beta blockers, quinine? ___yes ___no

Signature _____ Date _____

Reviewed by _____ Date_____