

International Travel Medical Questionnaire: Please fill out all questions completely prior to your appointment. Bring the completed form to your appointment.

Name: _____ DOB: _____
 Age: _____ Approximate Weight: _____ lbs/kg Sex: M / F
 Home Address: _____
 Home Phone: _____ Cell: _____ Work: _____

If traveling for business:

Company: _____
 Address _____ City _____ State _____ Zip _____

Travel Itinerary: Departure Date _____ Return Date _____

Please list in EXACT order of Travel:

Country	All Destinations	Length of Stay	Rural Travel	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Accommodations and Purpose of Travel Check all that apply

- Business
 Vacation
 Adoption
 Pilgrimage to Mecca
 Medical Volunteer
 Missionary
 Cruise Ship
 Private Home
 Camp
 Hotel
 Caving
 Safari
 Other _____

Does your trip involve ascending > 8,000 feet not including your airplane flight? ___ Yes ___ No
 If yes, how many times? _____

Accommodations:

- Modern Hotel
 With Local Family
 Youth Hostel
 Tent/Cabin
 With Relatives
 Other: _____

Planned Activities:

- Working in Medical/dental field
 Working with animals/birds
 Outdoor activity (i.e. camping/hiking)
 Snorkeling/Scuba diving
 Safari
 other: _____

Staying in area which is:

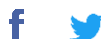
- Urban
 Rural
 High Altitude
 Other: _____

Traveling:

- Alone
 With Family/Friend
 In group
 Other: _____

Mission: To prevent disease and injuries, promote healthy living, protect the environment and ensure public health preparedness.
 Vision: Build a Healthier Linn County

EMAIL: health@linncounty.org | WEB: linncounty.org/health



Medications:

Please list all current medications, including oral contraceptives, herbal supplements, vitamins, and over the counter medications.

Drug Name	Dose Taken	Time Taken

I currently do not take any medications

Allergies:

List all allergies, including medications or foods.

Allergy To:	Reaction:

I currently do not have any allergies

Personal Medical Information:

Please check all that apply

<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	Depression
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Splenectomy	<input type="checkbox"/>	Hives
<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	Autoimmune disorder	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Blood clots/phlebitis	<input type="checkbox"/>	Asthma/COPD/Emphysema	<input type="checkbox"/>	Blood or Plasma Transfusion
<input type="checkbox"/>	G6PD deficiency	<input type="checkbox"/>	Recurrent Pneumonia	<input type="checkbox"/>	Measles/Mumps/Rubella
<input type="checkbox"/>	Liver/Kidney problems	<input type="checkbox"/>	Previous Travel Related Illness	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Severe Reaction to Vaccine	<input type="checkbox"/>	Stomach Ulcer
<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	HIV/Immune Deficiency	<input type="checkbox"/>	Hepatitis/Liver Disease

If yes to any, please explain and give dates:

Please list any other medical conditions not listed above:

Have you ever had any reaction to a vaccine? Yes No

Are you pregnant or plan on becoming pregnant in the next 3 months? Yes No

Note: If live vaccines are recommended (MMR, Yellow Fever, Varicella), it is advisable not to get pregnant for 4 weeks after receiving the vaccine.

Linn County Public Health request that you bring documentation of all of your past vaccinations to your appointment. It is also requested that you bring any paperwork sent to you per your travel agent or group representative that is working on your trip. This will help to expedite your appointment time and ensure that proper medications and vaccines are given.

To the best of my knowledge the above information I have provided about my medical history is correct.

Signature: _____ Date: _____