ADULT IMMMUNIZATION SERVICES
770 Welch Road, Suite 380, Palo Alto, CA 94304
Phone: (650) 324-1250 Fax: (650) 324-2557

TRAVEL QUESTIONNAIRE

Name ____ **Gender** _____ **Date of birth** __________ **Date** _______

Address_______________________________________ **Phone** ______________ **E-mail** ___________________

City/state/zip __________________________________ **Primary care physician** _________________________

<u>ITINERARY</u>: **Departure date** ____________ **Return date** ____________

<u>Destination (city or region and country)</u>: <u>Number of days at destination</u>:

____ ____

____ ____

____ ____

____ ____

Independent (fixed/flexible) ______ Guided/escorted ______ Accommodations (hotel/resort/camp/cruise) ______

Travel in rural areas ____________________________ Altitude (if over 5,000 feet) _______________________

Special activities (safari, handling wildlife, SCUBA diving, etc.) ____

Health concerns about trip ____

____

<u>MEDICAL HISTORY</u>:	**<u>Yes</u>**	**<u>No</u>**
Acute or chronic illness?	___	___
Seizure disorder?	___	___
Heart problem?	___	___
Immune deficiency (leukemia, cancer, HIV, etc.)?	___	___
Member of household with immune deficiency?	___	___
Allergy to eggs or other substances?	___	___
Allergy or sensitivity to medications?	___	___

<u>FOR WOMEN ONLY</u>:	**<u>Yes</u>**	**<u>No</u>**
Pregnant or might become pregnant?	___	___
Breastfeeding?	___	___

<u>Please note</u>:* *Women receiving live virus vaccines should <u>not</u> become pregnant for 3 months.

List: ____

List: ____

<u>CURRENT MEDICATIONS</u>: ____

<u>IMMUNIZATION HISTORY</u>: <u>(indicate last month and year that vaccine was administered)</u>

Tetanus _________ Polio (oral/injectable) _________ Measles/mumps/rubella _________ Influenza __________
Meningitis _________ Typhoid fever (oral/injectable) _________ Hepatitis A _________ Hepatitis B __________
Yellow fever _________ Other ____

<u>PATIENT AGREEMENT</u>:

I understand that questions on this form must be answered completely and to the best of my knowledge.

Signature ____ **Date** _______