OREGON HEALTH & SCIENCE UNIVERSITY

OHSU JBT HEALTH & WELLNESS CENTER
TRAVEL PATIENT QUESTIONNAIRE

Please fill out this form and bring it with you to your Travel appointment.

Name:_____Date of birth:_____Gender: ☐Male ☐Female
Address:_____Social Security #_____
Primary Contact #_____
Dates of vaccinations you may have had: (pre-entrance immunizations listed elsewhere)
Typhoid oral_____ injection_____ Polio_____
Yellow fever_____ JEV_____
Meningococcal_____

Circle any of the following that you are allergic to:
Eggs Thimerosal Sulfa Neomycin Streptomycin Bee stings
Other allergies:
Are you currently being treated for cancer? ☐Yes ☐No
Do you have a deficiency of the immune system? ☐Yes ☐No
Do you have any existing medical conditions, such as diabetes, heart disease, or lung cancer? ☐Yes ☐No
Please explain:
_____
_____

List all medication you are currently taking, either prescription or over-the-counter:
_____
_____
_____

INFORMATION ABOUT YOUR TRAVEL PLANS

Date of departure:_____Length of trip:_____
Please indicate, in the order in which you will visit them, the countries to which you will be traveling. Also indicate length and dates of stay in each country (bring complete details of itinerary to your appointment).
_____
_____
_____
_____
Is your travel to: urbanized areas rural areas Both
What is the reason for travel (pleasure, business, medical work, etc)?
_____

QUESTIONS FOR WOMEN

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? ☐Yes ☐No
Are you breast feeding? ☐Yes ☐No
If pregnant, how many weeks? _____
Do you have any special concerns or questions to be answered at your appointment?
_____
_____

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