CORNELL HEALTH
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INTERNATIONAL TRAVEL QUESTIONNAIRE

Date _____ Name _____

Phone (home) _____ ID _____ DOB _____

(work) _____ PCP _____ MRN _____

The answers you supply in this questionnaire will enable us to give the most accurate medical information and advice for your specific travel plans.

❑ I understand that if any post-travel medical condition should occur (fever, nausea, vomiting, rash, etc.) I should check with my medical provider upon return.

TRAVEL PLANS

Purpose(s) of trip (check all that apply):

❑ vacation ❑ education / research ❑ adoption ❑ visit friends or family ❑ to obtain medical or dental care

❑ missionary / volunteer / humanitarian relief ❑ work (urban, office-based, or conference)

❑ work (rural, outdoors, or in local community) ❑ other: _____

Planned activities:

❑ hiking ❑ camping ❑ mountain climbing ❑ scuba diving ❑caving

❑ other activities: _____

Will you be visiting areas that are:

Rural ❑ yes ❑ no ❑ unsure

Urban ❑ yes ❑ no ❑ unsure

Primitive or remote ❑ yes ❑ no ❑ unsure

Will you be:

Ascending to high altitudes (8,000 ft or higher)? ❑ yes ❑ no ❑ unsure

Working with potential exposure to body fluids (e.g., medical or dental work)? ❑ yes ❑ no ❑ unsure

Working with exposure to animals? ❑ yes ❑ no ❑ unsure

Potentially having new sexual partners? ❑ yes ❑ no ❑ unsure

Accommodation(s) (check all that apply):

❑ resort / large hotel ❑ small hotel / guest house / B&B ❑ cruise ship ❑ private home (with locals)

❑ private home (with relatives) ❑ private home (air conditioning; high end) ❑ primitive camping

❑ up-scale camp / lodge ❑ dormitory / hostel

❑ other accommodations: _____

Previous international travel (year and destination):

_____

_____

Departure Date from United States: _____ Return Date to United States: _____

Please list, IN ORDER, the countries, cities, towns or regions you will be visiting:

Country #1: _____

❑ urban ❑ rural **Arrival/departure dates or duration of visit:** _____

Country #2: _____

❑ urban ❑ rural **Arrival/departure dates or duration of visit:** _____

Country #3: _____

❑ urban ❑ rural **Arrival/departure dates or duration of visit:** _____

Country #4: _____

❑ urban ❑ rural **Arrival/departure dates or duration of visit:** _____

Country #5: _____

❑ urban ❑ rural **Arrival/departure dates or duration of visit:** _____

Please add any other areas you will be visiting during this trip: _____

_____

_____

_____

_____

HEALTH HISTORY (check all that apply)

Allergies:

❑ antibiotics ❑ egg ❑ latex ❑ gelatin ❑ yeast ❑ bees / wasps ❑ seafood ❑ seasonal ❑ other medication allergies

❑ side effects / reactions from previous medications (e.g., hives, shortness of breath, nausea, dizziness, stomach upset or life threatening event)

Please explain any allergic / adverse reactions checked above: _____

_____

_____

Cancers / blood disorders:

❑ coagulation disorder ❑ history of cancer or blood disorder ❑ other

Please explain: _____

_____

_____

Cardiovascular:

❑ arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block) ❑ stroke

❑ implanted pacemaker or automatic defibrillator ❑ heart attack ❑ high cholesterol ❑ high blood pressure ❑ other

Please explain: _____

_____

_____

Endocrine:

❑ diabetes ❑ thyroid ❑ other

Please explain any allergic / adverse reactions checked above: _____

_____

_____

Gastrointestinal:

❑ Crohn's disease or ulcerative colitis ❑ IBS ❑ GERD ❑ chronic hepatitis ❑ cirrhosis or liver failure ❑ other

Please explain: _____

_____

_____

Immune System:

❑ steroids by mouth within last 3 months ❑spleen removed ❑ thymus disease or thymectomy ❑ organ, bone marrow, stem cell transplant (give details and dates below) ❑ immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab ❑ HIV / AIDS (please write date and, if know, results, of most recent CD4 and most recent viral load in space below ❑ currently living with someone who is immunocompromised ❑ other

Please explain: _____

_____

_____

Kidneys:

❑ dialysis ❑ kidney insufficiency ❑ other

Please explain: _____

_____

_____

Lungs:

❑ asthma ❑ emphysema / COPD ❑ other

Please explain: _____

_____

_____

Musculoskelatal:

❑ RA ❑ psoriatic arthritis ❑ other

Please explain: _____

_____

_____

Neurologic / psychiatric:

❑ seizures or epilepsy ❑ anxiety / depression ❑ history of Guillain-Barre' ❑ other

Please explain: _____

_____

_____

Skin:

❑ psoriasis ❑ other

Please explain: _____

_____

OB / Gyn:

❑ pregnant (please add below how many weeks pregnant you are or which trimester you're in) ❑ breastfeeding

❑ possible pregnancy in next 3 months or plan to father ❑ taking oral combined birth control pill ❑ other

Please explain: _____

_____

_____

Previous diseases and infections possibly related to travel: Have you ever had any of the following?

Malaria	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No	Typhoid	❑ Yes ❑ No
Cholera	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Hepatitis B	❑ Yes ❑ No
Hepatitis C	❑ Yes ❑ No	Dysentary	❑ Yes ❑ No	Amebiasis	❑ Yes ❑ No
Giardia	❑ Yes ❑ No	Yellow Fever	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Dengue	❑ Yes ❑ No	Other	❑ Yes ❑ No		

Please explain any medical problems "yes" answers from above:

_____

_____

VACCINATION HISTORY (please bring all vaccination records to your appointment)

Have you received the following immunizations? (include date(s) if known)

Hepatitis A	❑ Yes ❑ No Dates:_____		Yellow fever	❑ Yes ❑ No	Dates:_____
Hepatitis B	❑ Yes ❑ No Dates:_____		Influenza	❑ Yes ❑ No	Dates:_____
Meningococcal	❑ Yes ❑ No Dates:_____		Yellow fever	❑ Yes ❑ No	Dates:_____
MMR	❑ Yes ❑ No Dates:_____		Rabies	❑ Yes ❑ No	Dates:_____
Polio	❑ Yes ❑ No Dates:_____		Typhoid	❑ Yes ❑ No	Dates:_____
Tetanus(TDAP)	❑ Yes ❑ No Dates:_____		Japanese Encephalitis	❑ Yes ❑ No	Dates:_____

Meningococcal ❑ Yes ❑ No ❑ Menactra **or** ❑ Menomune Dates:_____

Other? (list & dates) _____

Have you ever had an adverse reaction to an immunization? ❑ Yes ❑ No ❑ Unsure

Have you ever received INH or other tuberculosis medicine? ❑ Yes ❑ No ❑ Unsure

Have you ever received a tuberculosis skin test (PPD) or Quantiferon blood test? ❑ Yes ❑ No ❑ Unsure

If yes, date of your most recent test: _____ Results: ❑ Positive ❑ Negative

CURRENT MEDICATIONS

Please list all current prescription medications as well as the reason for use / medical condition:

_____

_____

_____

_____

Please list all current non-prescription products you are using. List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc., and the reason for use / medical condition.

_____

_____

_____

_____

QUESTIONS / CONCERNS

Additional questions or concerns about your travel:

_____

_____

_____