Your Health Our Priority
NEW HANOVER COUNTY HEALTH DEPARTMENT

New Hanover County
International Travel Clinic

_____
Name (Please Print)

PATIENT QUESTIONNAIRE

ITINERARY

List the countries/cities you will be visiting. The United States will be your country of origin.

Country		**City/Number of days visiting**	
Country		**City/Number of days visiting**	
Country		**City/Number of days visiting**	
Country		**City/Number of days visiting**	
Leaving the United States on this Date: _____			**Returning to the United States on this Date:** _____
Will the trip be (check all that apply): ☐Urban ☐Rural ☐ Both			**ACCOMMODATIONS: (check any that apply)** ☐Ship ☐Hotel ☐Camp/Tent ☐Dormitory ☐Private Residence/home

ALLERGIES/ MEDICAL CONDITIONS

1. Are you allergic to any medicines?	☐ **No** ☐ **Yes Please List:**
2. Are you pregnant or contemplating pregnancy?	☐ **No** ☐ **Yes** ☐ **Not Applicable**
3. Are you breastfeeding?	☐ **No** ☐ **Yes** ☐ **Not Applicable**
4. Are you currently using a method of birth control?	☐ **No** ☐ **Yes What Type?**
5. Have you had any severe reactions to past vaccines?	☐ **No** ☐ **Yes Please List:**

6. List all medications you are currently taking, either prescription or over-the-counter (attach list if needed):

7. Do you have any medical conditions, such as diabetes, heart disease, or lung disease? Please explain below:

IMMUNIZATION RECORD

Please note below any vaccinations and/or diseases you have had with the dates.
PLEASE BRING YOUR IMMUNIZATION RECORD WITH YOU TO YOUR APPOINTMENT

Immunization History	Date	Date	Date	Disease, please state year	Unknown
Hepatitis A (2 doses)					
Hepatitis B (3 doses)					
Hepatitis A/B (3 doses)					
Influenza					
Japanese Encephalitis					
Meningococcal					
MMR (Measles, Mumps, Rubella)					
Pneumococcal (Pneumonia)					
Polio Booster					
Pre- or Post- Rabies Series					
Shingles					
Tetanus diphtheria (Td) pertussis (Tdap)					
Typhoid					
Varicella (Chicken Pox)					
Yellow Fever					

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PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES, NO OR UNKNOWN	
1. Do you have sensitivity to sodium chloride, sorbitol or have been diagnosed with multiple sclerosis (MS)?	☐ **No** ☐ **Yes** ☐ **Unknown**
2. Are you allergic to gelatin?	☐ **No** ☐ **Yes** ☐ **Unknown**
3. Do you have sensitivity to yeast extract, casein, dextrose, galactose, sucrose, ascorbic acid, amino acids, lactose, or magnesium stearate?	☐ **No** ☐ **Yes** ☐ **Unknown**
4. Do you have an allergy to natural latex rubber?	☐ **No** ☐ **Yes** ☐ **Unknown**
5. Do you have sensitivity to protamine sulfate?	☐ **No** ☐ **Yes** ☐ **Unknown**
6. Do you have an allergy to thimerosal?	☐ **No** ☐ **Yes** ☐ **Unknown**
7. Do you have an allergy to yeast?	☐ **No** ☐ **Yes** ☐ **Unknown**
8. Do you have an allergy to neomycin?	☐ **No** ☐ **Yes** ☐ **Unknown**
9. Are you allergic to eggs or chicken protein?	☐ **No** ☐ **Yes** ☐ **Unknown**
10. Are you allergic to processed bovine gelatin, chlortetracycline, or amphotericin B?	☐ **No** ☐ **Yes** ☐ **Unknown**
11. Do you have sensitivity to phosphate or glutamate?	☐ **No** ☐ **Yes** ☐ **Unknown**
12. Are you immunosuppressed due to HIV, leukemia, lymphoma, thymic disease, generalized malignancy, corticosteroid therapy, alkylating drugs, antimetabolites, or radiation?	☐ **No** ☐ **Yes** ☐ **Unknown**
13. Do you have a history of thymus disease, myasthenia gravis, DIGeorge syndrome or thymoma?	☐ **No** ☐ **Yes** ☐ **Unknown**
14. Have you had removal of part of your intestine?	☐ **No** ☐ **Yes** ☐ **Unknown**
15. Are you taking sulfonamides or antibiotics?	☐ **No** ☐ **Yes** ☐ **Unknown**
16. Are you currently experiencing an acute gastrointestinal illness?	☐ **No** ☐ **Yes** ☐ **Unknown**
17. Do you have a history of Guillian-Barre Syndrome?	☐ **No** ☐ **Yes** ☐ **Unknown**
18. Have you had a past reaction to pertussis (whooping cough) vaccine?	☐ **No** ☐ **Yes** ☐ **Unknown**
19. Do you have a history of a progressive neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy?	☐ **No** ☐ **Yes** ☐ **Unknown**
20. Do you have thrombocytopenia?	☐ **No** ☐ **Yes** ☐ **Unknown**
21. If female, are you breastfeeding?	☐ **No** ☐ **Yes** ☐ **Unknown**
22. Do you desire anti-malarial medications?	☐ **No** ☐ **Yes** ☐ **Unknown**
23. Do you desire a prescription for the treatment of Traveler's Diarrhea?	☐ **No** ☐ **Yes** ☐ **Unknown**

_____ _____
Patient's Signature *Date*

_____ _____
Reviewed by *Date*

RETURN COMPLETED FORM ONE (1) WEEK PRIOR TO SCHEDULED APPOINTMENT:
Fax to: (910) 772-7805
Or
Mailing/Hand Delivering to: New Hanover County Health Department
Attention: Travel Clinic
2029 South 17th Street, Wilmington NC 28401