Infectious Diseases Consultants of Oklahoma City

Travel Clinic Questionnaire

Patient Name: ______________________.
DOB:__/__/____. ❑ first visit ❑ return visit
Adress:______________________________
Phone: ______________________________

Primary Purpose of travel:

❑ Business ❑ Personal ❑ Mission ❑ Other

Destinations *(list countries in the order you will be visiting them.)*

Country	Urban	Rural	Length of Stay	Purpose of visit
	(check one or both)			
1. ______________________________	❑	❑	__________	_______________
2. ______________________________	❑	❑	__________	_______________
3. ______________________________	❑	❑	__________	_______________
4. ______________________________	❑	❑	__________	_______________
5. ______________________________	❑	❑	__________	_______________
6. ______________________________	❑	❑	__________	_______________

Date of Departure from the United States_____/___/____

Date of Return to the United States_________/___/____

Activities:

Will you be undertaking any of the following activities?

❑ Hiking
❑ Cave Exploring
❑ Handling Animals
❑ Archaeology
❑ High altitude activities
❑ Working in a medical setting
❑ Swimming in local bodies of water
❑ Bicycling
❑ Anthropology
❑ Biology
❑ Safari
❑ Other_________________

Lodging (one or more)

❑ Affluent Hotels
❑ Hostels
❑ Staying with a local resident/family
❑ Camping/Adventure Travel
❑ Dormitory
❑ Other______________________________

Name:____________________________

Medical History:

Do you have a history of:

- ❑ Diabetes
- ❑ Heart Disease
- ❑ Chronic Lung Disease
- ❑ Asthma
- ❑ HIV or AIDS
- ❑ Chronic Hepatitis C
- ❑ Chronic Liver Disease
- ❑ Epilepsy
- ❑ Removal of the spleen
- ❑ Peptic Ulcer Disease
- ❑ Do you have an artificial heart valve?
- ❑ Myasthenia Gravis
- ❑ Chronic Kidney Disease
- ❑ Cancer
- ❑ Are you taking chemotherapy now?
- ❑ Chronic Steroid Therapy
- ❑ Immune disorder
- ❑ Cystic fibrosis
- ❑ Are you on blood thinners?
- ❑ Psychiatric disease
- ❑ Have you ever attempted suicide?
- ❑ Have you had your thymus removed?
- ❑ Other______________________

Do you have any other chronic medical conditions, conditions with a potential for relapse, or other conditions for which you are seen regularly by a medical professional?

❑ yes ❑ no

If so, what is the condition?

____

Do you live with anyone or have close contact with a person/people living with one of the following conditions?

HIV or AIDS Cancer Immune disorder

❑ yes ❑ no

Allergies:

Do you have any medication allergies?

❑ yes ❑ no

If so, what is the medication?

____
____
____
____
____

Are you allergic to any of the following compounds?

❑ eggs	❑ insect bites	❑ sunlight sensitivity
❑ thimerosal	❑ penicillin	❑ food______________________
❑ mercury	❑ sulfa	❑ other______________________
❑ vaccines	❑ seafood	

Women only:

Are you pregnant, suspect you are pregnant, or trying to become pregnant? ❑ yes ❑ no

Are you breastfeeding? ❑ yes ❑ no

Name:____________________________

IMMUNIZATION HISTORY

(Please list all previous vaccinations here)

Vaccine	Date and dosage (if known)					Booster doses	
	1	2	3	4	5	1	2
Yellow Fever							
Cholera							
Measles							
Mumps							
Rubella							
MMR							
(Measles, Mumps, & Rubella)							
Tetanus							
Td							
TdAP							
DTP							
Polio (oral or injectable)							
Typhoid (oral or injectable)							
Hepatitis A							
Hepatitis B							
Hep A/B (twinrix)							
Rabies							
Plague							
Japanese Encephalitis							
Meningococcal							
Influenza							
Pneumococcal							
Varicella							
Haemophilus influenza B							
Tuberculin PPD test							

If at all possible, please bring a copy of your vaccination record with you on the day of your visit.

Medications:

Are you taking any medications?

Medication	**Dosage**	**Frequency** *(twice daily, etc.)*

Is there any other information you would like us to know regarding your travel plans or your medical history?

____

____

____

____

____

Your signature implies that all necessary medical information has been provided to the best of your knowledge.

Patient Signature: ______________________________ ***Date:*** _____/____/__________

Name: ____________________________

OFFICE USE ONLY

	Recommended	Date	Date	Date	Date	Date	Price*	Declined
Consult	❑						65	
Yellow Fever Card	❑						6	
Yellow Fever	❑						170	
Cholera	❑						N/A	
Measles	❑						N/A	
Mumps	❑						N/A	
Rubella	❑						N/A	
MMR	❑						70	
Tetanus	❑						25	
Td	❑						25	
TdAP	❑						95	
Polio	❑						35	
Typhoid	❑						60	
Hepatitis A	❑						80	
Hepatitis B	❑						70	
Hep A/B	❑					325	115	
Rabies	❑						TBD	
Plague	❑						TBD	
JEV	❑						TBD	
Meningococcal	❑						135	
Influenza	❑						25	
Pneumococcal	❑				Pneumovax 115	Prevnar 230	115/230	
Varicella	❑						155	
PPD	❑						20	

*Prices of vaccines are subject to change without prior notice

* Administration Fee $20.00 for 1st vaccines, $10.00 for each one after that.

Malaria: ❑prophylaxis rec
❑no proph rec

CQ
pills_____

Malarone
pills_____

Mefloquine
pills_____

Doxycycline
pills_____

Primaquine
pills_____

❑ Bednets
❑ Repellent
❑ Clothing

Traveller's Diarrhea

❑water
❑bismuth subsalicylate (Pepto-Bismol)
2 tabs or 1 oz. Q 30 mins
up to 8 doses
❑Loperamide
4mg x 1 then 2mg after
each loose stool ≤16mg/d

❑antibiotic
FQ # pills_____.
❑ Cipro 500 bid
❑ Levoflox 500 qd
Rifaximin
❑ 200mg tid
Macrolide
Azithro 1gm x one

Topics:
Traveller's diarrhea ❑

Insect protection ❑

Traveler's Insurance ❑

Alcohol/drug use ❑

Insomnia/jet lag ❑
❑ Ambien

Other: ____

____

____

____

____

____

DAVID H. CHANSOLME M.D.,P.C

4221 S. WESTERN AVE STE 5050, OKLAHOMA CITY, OK 73109 405-644-6464

Name:_______________________________

Immunization Record

Vaccine
Date / /
Lot number
Exp. Date / /
Administered by:

Vaccine
Date / /
Lot number
Exp. Date / /
Administered by:

Vaccine
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