Sentara Martha Jefferson Traveler's Clinic
QUESTIONNAIRE

500 Martha Jefferson Drive, Phillips Cancer Center 5th floor, Charlottesville VA, 22911
Ph: 434-654-5260 Fax: 434-654-5261

The answers you give on this questionnaire will enable us to provide you with the most accurate information for you, your health needs and specific travel itinerary. You will be receiving individualized advice and care based on this questionnaire.

NAME (Last, First, M.I.): _____ PHONE: _____
ADDRESS: _____
GENDER: _____ DOB: _____ Countries where you grew up: _____
Referred By: _____ PCP: _____
Traveling through agency or group? Traveling for work? (Agency/business name and contact information) : _____
_____
_____
Travel companions (age, name, relationship): _____
_____
_____
Previous countries visited: _____
_____
_____

ITINERARY (include airport layovers)

Departure date: _____ Return date: _____

Country	City	Arrival Date	Departure Date

PURPOSE

__ Adopting a child
__ Adventure
__ Business
__ Disaster relief
__ Education
__ Long term travel
__ Mission work
__ Providing humanitarian healthcare
__ Receiving healthcare
__ Religious/pilgrimage
__ Travel for mass gathering
__ Vacation
__ Visiting family/friends
__ Other

ACCOMMODATIONS

__ Boat/Cruise
__ Compound
__ Dorm/Hostel
__ Hotel/Resort
__ Private Home
__ Tent/Hut/Outdoor
__ Other

ACTIVITIES

__ Adventurous eating
__ Altitude > 8,000 ft
__ Animal contact (what kind? _____)
__ Hiking/Camping
__ New sexual contact
__ Safari
__ Scuba Diving
__ Spelunking (caving)
__ Swimming/Rafting (fresh water)
__ Swimming/Rafting (ocean)

VACCINATION HISTORY Please complete accurately to avoid receiving unnecessary vaccines

(check "Had Disease" if applicable or list dates of vaccination)	Had Disease	Date(s)
Childhood vaccines		
DTap (Diphtheria, tetanus, pertussis)		
HiB (Haemophilus influenza, type B)		
HPV (Human papilloma virus)		
MMR (Measles, mumps, rubella)		
Polio		
Rotavirus		
Childhood or Adult vaccines		
Hepatitis A		
Hepatitis B		
Hepatitis A/B combination		
Meningitis ACWY		
Meningitis B		
Varicella (chickenpox)		
Adult vaccines		
Prevnar13 (pneumonia)		
Pneumovax (pneumonia)		
Shingles		
Td (Tetanus, diphtheria)		
Tdap (Tetanus, diphtheria, pertussis)		
Annual vaccines		
Influenza		
Travel vaccines		
Cholera (oral)		
Dengue fever		
Japanese encephalitis		
Rabies		
Typhoid injection (inactivated)		
Typhoid oral (live)		
Yellow Fever		
Other		

Have you had any immunizations in the past 30 days? _____
Have you ever had an adverse reaction to an immunization? _____
Do you have an "International Certificate of Vaccination" or Yellow Card? _____

HEALTH HISTORY

Medical conditions: _____
_____
_____
_____

Check all that apply:

__ Pregnant
__ Any chance of pregnancy
__ Planning pregnancy in next 3 months
__ Breastfeeding
__ Psychiatric condition
__ Heart conduction abnormality
__ Psoriasis
__ Kidney Disease
__ Liver Disease
__ Thymus disease or history of thymectomy
__ Severe egg allergy
__ Immune system disorder
__ immune-suppressing medication
__ Received blood/blood products
__ Seizure disorder

List all current prescription and non-prescription medications: _____
_____
_____

List all allergies: _____
_____
_____

_____ **_____**
Patient Signature **Date**

6/4/19 KH/mda