UW MEDICINE TRAVEL CLINIC at HALL HEALTH CENTER

TRAVEL PLANNING QUESTIONNAIRE

Please complete both sides and bring to your appointment

Name:	**Age:**	**Date:**

How did you hear about our clinic?
- ☐ UW student
- ☐ Employer
- ☐ Web
- ☐ UW faculty/ staff
- ☐ Hall Health patient
- ☐ Other
- ☐ PCP (Name and Address):

Our patients are welcome to contact us by email at travel@uw.edu with questions and concerns. Do we have your permission to communicate travel medicine information related to your care by email? ☐ Yes ☐ No

Email address:	Phone number:

TRAVEL ITINERARY

Date of Departure:	**Date of Return:**	**Length of Trip:**

Countries/Cities/Regions and Approximate Dates:	**Planned Activities:**

Purpose of Travel:

(Expected) **Accommodations:**

MEDICAL HISTORY

Have you traveled to developing countries in the past? ☐ No ☐ Yes; *if yes, please indicate the regions below*:
☐ Africa ☐ Asia ☐ South America ☐ Central America ☐ Other?

Have you ever had a reaction to a **medication, vaccine, food, bee/insect, other** (rash, breathing difficulties, stomach upset)?
☐ No ☐ Yes; *if yes, explain (what drug or vaccine, what type of reaction, how long after administration?):*

Do you have any symptoms of acute illness today? ☐ No ☐ Yes; *if yes, please explain:*

Please list any chronic or acute medical conditions for which you are currently being treated:

Do you have a history of blood clotting disorder, previous deep vein thrombosis (DVT), or pulmonary embolism (PE)? ☐ Yes ☐ No

List all **current medications** and **dosages**, if known (prescriptions and over the counter, including birth control):

Additional comments (pertinent health history, concerns about the trip?)

FOR WOMEN: Are you currently sexually active with men? ☐ No ☐ Yes
Method of contraception? ☐ IUD ☐ Pill/OCP ☐ Condom ☐ Implant ☐ Injection ☐ Vasectomy ☐ Other?
Are you currently pregnant or attempting pregnancy? ☐ No ☐ Yes
Are you breastfeeding? ☐ No ☐ Yes Date of last menstrual period: / /

1. If you have your vaccine records with you, we prefer to enter these records in your chart at the time of your visit. We make every attempt to enter vaccine information before your visit if it has been faxed.

2. Did you receive the typical “routine” childhood vaccinations? ☐ Yes ☐ No ☐ Don’t know

3. Have you had any blood transfusions or received blood products in the last 11 months? ☐ No ☐ Yes (Date): ______

VACCINE HISTORY–FILLED OUT BY PROVIDER

VACCINE AND ROUTE	MO/DAY/YR	VACCINE AND ROUTE	MO/DAY/YR
Hepatitis A – 1 / 2		Pneumococcal polysaccharide PPV23	
Hepatitis B – 1 / 2 / 3		Pneumococcal conjugate PCV13	
Twinrix (combined Hep A/B) – 1 / 2 / 3		Polio (IPV)	
Additional Hepatitis B or Twinrix		Rabies vaccine – 1 / 2 / 3	
HPV (Human Papillomavirus) 1/ 2/ 3		Td	
Influenza (flu) vaccine		Tdap/DTap	
Intranasal flu		Injectable typhoid	
High dose flu		Oral typhoid (4 tabs)	
Japanese Encephalitis (JEV/Ixiaro) – 1 / 2 or booster		Varicella (Chicken Pox) disease (yes or no)	
Measles, Mumps, & Rubella (MMR) – 1 / 2		Varicella (Chicken Pox) vaccine – 1 / 2	
HPV (Human Papillomavirus) 1 / 2 / 3		Yellow Fever	
Meningococcal B (Bexsero) 1/ 2		Zostavax (for shingles – Herpes zoster, 60+)	
Meningococcal B (Trumenba) 1 / 2 / 3			
Meningococcal, polysaccharide			
Meningococcal conjugate (2005)			

WORKSHEET FOR TRAVEL-RELATED MEDICATIONS

Allergic response
- ☐ EpiPen (epinephrine)

Altitude Sickness
- ☐ Acetazolamide (Diamox)125mg
- ☐ Dexamethasone 4mg

Diarrhea
- ☐ Azithromycin (Zithromax) 250 mg
- ☐ Ciprofloxacin (Cipro) 500 mg
- ☐ Rifaximin (Xifaxan) 200 mg

Malaria
- ☐ Chloroquine phosphate (Aralen)
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Doxycycline
- ☐ Mefloquine (Lariam)
- ☐ Atovaquone/Proguanil (Malarone)

Motion Sickness
- ☐ Transderm Scop (scopolamine patch)

Skin Infection
- ☐ Cephalexin (Keflex)
- ☐ Mupirocin ointment (Bactroban)

Yeast Infection
- ☐ Fluconazole (Diflucan)