INFECTIOUS DISEASES TRAVEL MEDICINE CLINIC QUESTIONNAIRE

Date: _____
Name (last, first) _____ Date of Birth _____ Age _____
Address _____
City, State, Zip _____
Phone Number _____ Gender ☐ M ☐ F
Departure Date: _____ Return Date: _____ Length of stay (weeks) _____
Country (S) in order of travel

_____

_____

Please indicate what your travel plans include by answering all of the following questions (check all that apply)

Is your journey related to: ☐ Business ☐ Tourism ☐ Study ☐ Visiting Homeland

Travel Accommodations: ☐ Resort ☐ Economy ☐ Hostel ☐ Private Home ☐ Camping

Will your visit be: ☐ Urban ☐ Rural ☐ Combined

Anticipated travel activities: ☐ Biking ☐ Medical work ☐ Hiking/trekking

☐ High altitude visit ☐ Scuba diving ☐ Sight seeing ☐ High altitude climb

MEDICAL HISTORY

Are your aware of any **allergies** to:

☐ Antibiotics (specifically Neomycin, Streptomycin, Polymixin)

☐ Mercury, Thimerosal or Sulfites

☐ Bee Stings (experience hives?)

☐ Yeast or Eggs

☐ Other allergies _____

Medications: Please list **ALL** medications that you take (name of medication only)

_____

_____

Please answer Yes or No to ALL questions:

Are you being treated for leukemia, lymphoma or any malignant disease? ☐ Yes ☐ No

Is there any possibility you may have an immune system deficiency? ☐ Yes ☐ No

Are you on steroids? ☐ Yes ☐ No

Do you have sickle cell, G6PD, low platelet count or bleeding? ☐ Yes ☐ No

Do you have impaired gastric defenses of use antacids heavily? ☐ Yes ☐ No

Do you have diabetes, heart disease, lung disease or liver disease? ☐ Yes ☐ No

Have you ever had a seizure, convulsion or epilepsy? ☐ Yes ☐ No

Do you have a history of psoriasis? ☐ Yes ☐ No

Are you pregnant, trying to become pregnant or breastfeeding? ☐ Yes ☐ No

Have you had any immunizations in the past month? ☐ Yes ☐ No

Have you ever had a reaction to immunizations? ☐ Yes ☐ No

Do you live with anyone who has an immune system deficiency? ☐ Yes ☐ No

Do you live with anyone who is on chemotherapy for cancer? ☐ Yes ☐ No

When was you last tetanus shot?_____ ☐ Yes ☐ No

The services rendered at the OSU Infectious Diseases Travel Clinic are not covered by Medicare and therefore, you may be asked sign the attached Advanced Notice of Non-Coverage form. OSU Infectious Diseases Travel Clinic will file claims, but only upon your specific request. However, payment is due at the time of service.

For all non-Medicare patients, payment is due at the time of service by credit card, cash or check.

The above information is accurate to the best of my knowledge. I understand that insurance may not cover travel related immunization services and that I am responsible for all fees due at time of service. I understand that I will be given an immunization record listing all vaccines received and that I am responsible for keeping this safe and up-to-date. Inactive records are kept on file for 3years at the OSU Infectious Diseases Travel Clinic and are confidential.

May we send your primary care physician a copy of your immunization record? ☐ **Yes** ☐ **No**

Physician's name & address:

_____

_____

Traveler/patient signature: _____ **Date:** _____

Travel Health Nurse/Physician: _____ **Date:** _____

Please print form then and return it to the Travel Medicine Clinic **prior to your appointment.**

fax to secure fax number 614- 293-8102 Attention Diane Orlov, CNP
or
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or
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