Threlkeld, Threlkeld & Omer, PLLC **6029 Walnut Grove Rd, Suite C002** **Memphis, TN 38120**	**Travel Medicine Questionnaire**

Clearly PRINT All Information

Legal Name of Traveler:			
Gender:	DOB: / /	Birthplace:	
Home Address:			
	City:	State:	Zip:
Home Phone:		Business Phone:	
Primary Care Physician:		Phone:	
Emergency Notification:		Phone:	
Relationship:			

ITINERARY:

Departure Date:	Return Date:	Length of Trip:

PURPOSE OF TRAVEL:

☐ Business	☐ Field Work	☐ Relocation	☐ Teaching/Study	☐ Missionary Work
☐ Vacation	☐ Diving	☐ Safari	☐ Climbing	☐ Other

Please explain, if other:

TYPE OF TRAVEL:

☐ Group/Tour	☐ Independent	☐ Fixed Itinerary
☐ Flexible Itinerary	☐ Cruise	☐ Other

ACCOMMODATIONS:

☐ Compound	☐ Hotel/Resort	☐ Private/Rented Home	☐ Cruise Ship	☐ Off Shore Rig

DESTINATION, INCLUDING AIRPORT STOPOVERS, IN ORDER OF TRAVEL:

Country	City	Duration	Urban	Rural

IMMUNIZATION HISTORY: (Check "had disease" if applies or list date of vaccine in appropriate box)					
	Had Disease	Vaccine#1/Date	Vaccine#2/Date	Vaccine#3/Date	Not Known
Chickenpox(Varicella)					
Hepatitis A					
Hepatitis B					
Rabies					
Japanese Encephalitis					
Measles					
Mumps					
Rubella					
Meningitis					
Polio					
Pneumococcal					
Influenza					
Tetanus/Diphtheria					
Typhoid Injection					
Typhoid Oral					
Yellow Fever					

Do you have an "International Certificate of Vaccination"?			☐ Yes	☐ No	
Vaccines?	☐ Yes	☐ No	Bee Stings?	☐ Yes	☐ No
Do you have cancer, leukemia, AIDS, or other immune system problems?				☐ Yes	☐ No
Do you take Cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation therapy?				☐ Yes	☐ No
Have you received a blood transfusion, blood products or immune globulin in the past year?				☐ Yes	☐ No
Have you had any immunizations in the past 4 weeks?				☐ Yes	☐ No

☐ Explain **YES** answers:

HEALTH HISTORY:

Weight:	Height:	Allergies:

MEDICATIONS: (List all medication, including dosages)

PRESCRIPTION	**NON-PRESCRIPTION**

Medical Conditions:

Previous Surgery:

Check if you have present or past history of the following:

Nightmares	☐ Yes	☐ No	Psoriasis	☐ Yes	☐ No	Seizure/Epilepsy	☐ Yes	☐ No
Psychiatric Disorders/Depression			☐ Yes	☐ No	Stomach/Colon Problems		☐ Yes	☐ No
Renal impairment/ renal disease			☐ Yes	☐ No	Hepatitis		☐Yes	

Women: Type of contraception_____(give Name Brand)

Pregnant?	☐Yes	☐No	Planning pregnancy within 3months?	☐Yes	☐No	Nursing?	☐Yes	☐No