HealthCare

- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Heatlh Clinics

PRE-TRAVEL QUESTIONNAIRE

(Patient Label Here)

SECTION ONE - PERSONAL INFORMATION AND ITINERARY

Name: ______________________________ Today's date: ______________

Who referred you to our clinic? ______________________________

Age: ________ Date of departure: ______________ Date of return: ______________

Purpose of travel: Pleasure / vacation ______ Religious ______ Medical ______

Business/education ______ ______________________________
(Company name / affiliation)

How many times have you traveled to developing countries:

Never ______ Once ______ Twice ______ Three times ______ Four or more times ______

To which countries have you been? ______________________________

Countries on itinerary (in order of travel and note major forms of transportation):

	COUNTRY	MODE OF TRANSPORTATION	EXPECTED DURATION OF STAY
1.	________	________	________
Cities: (a)	________	________	________
(b)	________	________	________
(c)	________	________	________
2.	________	________	________
Cities: (a)	________	________	________
(b)	________	________	________
(c)	________	________	________

Additional countries anticipated for future travel: ______________________________

Check all that apply to your travel plans.

______ Major resort hotels
______ Small hotels
______ Youth hostel
______ Rented foreign home
______ Staying with a family
______ Cruise ship
______ Camping
______ Safari
______ Rural travel
______ Outdoor activities
______ Organized tour group
______ Other (please specify)

M8-0465

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PRE-TRAVEL QUESTIONNAIRE (cont.)

(Patient Label Here)

Will you be participating in physically strenuous activities (skiing, mountain climbing, SCUBA diving, hiking, activities at above 5,000 feet?) _____ No _____ Yes

If yes, have you been involved in conditioning activities? _____ No _____ Yes

SECTION TWO - PERSONAL HEALTH ISSUES

Allergies

_____ Bee / insect stings

_____ Seasonal

_____ Thimerosol / mercury

_____ Eggs

_____ Drugs

1. _________________________

2. _________________________

_____ No known allergies

Allergy medications:

1. _________________________

2. _________________________

3. _________________________

Significant medical conditions

_____ Altitude sickness

_____ Anemia

_____ Asthma

_____ Blood clots

_____ Blood transfusion in the last year

_____ Cancer

_____ Depression or other psychiatric disorder

_____ Diabetes (H)

_____ Insulin dependent

_____ Eye disease

_____ Stomach / intestinal problems

_____ G6PD deficiency

_____ Hearing impaired

_____ Heart disease

_____ Require oxygen

_____ Pacemaker

_____ Hypertension

_____ Hepatitis

_____ **NONE OF THE ABOVE**

_____ HIV / AIDS

_____ Immune deficiency

_____ Liver disease

_____ Lung disease

_____ Require oxygen

_____ Malaria

_____ Motion sickness

_____ Myasthenia gravis

_____ Parasitic disease

_____ Physically challenged

_____ Psoriasis

_____ Pregnancy (H)

Due date: ______________

_____ Sickle cell disease

_____ Splenectomy

_____ Past travel illness with jaundice

_____ Thymus disease

_____ Traveler's diarrhea

_____ Other:

____

PRE-TRAVEL QUESTIONNAIRE (cont.)

(Patient Label Here)

Do you currently take any medications or food supplements? ______ No ______ Yes

If yes, please list the name of the medication, indication, and dose. List both prescription and over-the-counter medications. ______________________________

____

Have you received a transfusion of blood products in the last 6 months?

If yes, indicate the blood type and date: ______________________________

SECTION THREE - IMMUNIZATIONS

Usual childhood immunizations ______ No ______ Yes

Vaccinations as an adult ______ No ______ Yes If yes, please indicate below which ones and most recent date.

Vaccination	Date	Vaccination	Date
______ Hepatitis A		______ Hepatitis B	______
Dose 1	______	______ Pneumovax	______
Dose 2	______	______ Influenza	______
______ MMR booster	______	______ TB skin test	______
______ Tuberculosis BCG	______	______ Polio	______
______ Typhoid		______ Japanese encephalitis	______
Oral	______	______ Meningococcus	______
Injection	______	______ Tetanus / diphtheria	______
______ Rabies	______	______ Yellow fever	______
______ Cholera	______	______ Immune globulin	______
______ Plague	______	______ Varicella	______
______ Other	______		

Do you live or work closely with anyone who has an immune deficiency? ______ No ______ Yes

Have you used malaria prophylaxis medications in the past? ______ No ______ Yes

If yes, please indicate below which ones. Please note any side effects / adverse reactions.

	Side effects?		Side effects?
______ Mefloquine (Lariam)	______	______ Primaquine	______
______ Chloroquine (Aralen)	______	______ Doxycycline	______
______ Hydroxychloroquine (Plaquenil)	______	______ Maloprim	______
______ Proguanil	______	______ Malarone	______

PRE-TRAVEL QUESTIONNAIRE (cont.)

(Patient Label Here)

THE FOLLOWING SECTIONS TO BE COMPLETED BY PROVIDER

SECTION FOUR - COUNSELING

PRE-TRIP COUNSELING AREAS

_____ Travel insurance

_____ Travel medicine kit

_____ Conditioning for athletic trip

_____ Carry-on medications

_____ Motion sickness

_____ Jet lag / time zone adjustment

- _____ Melatonin

_____ Arrangements for medical needs

_____ Dental status

IN-FLIGHT COUNSELING AREAS

_____ Effects of alcohol / caffeine at high altitude

_____ In-flight activity to reduce clotting

_____ Hydration (low humidity)

_____ Lumbar and neck support

DESTINATION COUNSELING AREAS

_____ Sun protection

- _____ SPF 30 UVA & UVB
- _____ Sunglasses

_____ Traveler's diarrhea

- _____ Food & water precautions
- _____ Medical attention for symptoms

_____ Water precautions

_____ Blood supply in developing countries

_____ Safe sex precautions

_____ Altitude

_____ Insect precautions

- _____ Picardin _______________ %
- _____ DEET ________________ %
- _____ Permethrin

_____ Auto safety

- _____ e.g. rentals, laws, what side of road

_____ Local laws and customs

_____ Maps reviewed

- _____ Malaria
- _____ Yellow fever
- _____ Other _______________________________

POST-TRIP COUNSELING AREAS

_____ Follow-up appointment indicated

_____ Follow-up TB skin test indicated

_____ Indications for follow-up:
Persistent fever or diarrhea
New persistent cough
Unexplained weight loss
Night sweats

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SECTION FIVE - ASSESSMENT AND RECOMMENDATIONS

Height:_____________ Weight: _____________ Temp:_____________ Pulse: _____________

Syringe / medication letter given: _____Not indicated _____Yes _____No Date sent: ____________________

Adequate prescription medications for trip: _____Yes _____Not applicable ____No

_____ Prescriptions written _____Referred to primary physician

Post-trip evaluation recommended? _____No _____Yes Date: ________________________

(Recommended for trip over 3 months in duration or for specific health problems.)

IMMUNIZATIONS (usual adult doses)

1. _____ Hepatitis A vaccine (1.0ml IM)
2. _____ Hepatitis A vaccine peds (0.5ml IM)
3. _____ Hepatitis B (1.0 ml days 0, 30,180)
4. _____ Influenza (0.5 ml IM)
5. _____Japanese encephalitis (days 0, 28)
6. _____ MMR booster [a] (0.5ml SC)
7. _____ Meningococcus (0.5ml IM)
8. _____ Pneumovax (0.5 ml IM/SC)
9. _____ Polio (0.5ml IM)
10. _____ Cholera (Vaxchora)[a]
11. _____ Rabies (0.1ml IM days 0, 7,21/28)
12. _____ Tetanus / diphtheria (0.5 ml IM)
13. _____ TB skin test
14. _____ Typhoid[b]
    - _____ Typhom Vi (0.5ml IM)
    - _____ Orala (1po QODx4)
15. Varicella[a] (0.5cc sub-q; second 4-8 weeks)
16. _____ Yellow fever [a,c] (0.5 ml SC)
17, _____ Other ______________________________

_____ None ______________________________

a. Live vaccine b. Contraindicated if allergic to thimerosol c. Contraindicated if allergic to eggs.

MALARIA PROPHYLAXIS

_____ No prophylaxis recommended

_____ Mefloquine (Lariam) 250 mg/week (Rx # ________________________________)
(Not for use with beta blockers calcium channel blockers, pregnancy, history of Epilepsy or psychiatric problems)

_____ Chloroquine (Aralen) 500 mg/week (Rx # ________________________________)
(Lessen side effects by taking with meals or divided into twice weekly doses. Contraindicated with psoriasis)

_____ Doxycycline (Vibramycin) 100 mg/day (Rx # ________________________________)
(Not for use with pregnancy, children younger than 8 yrs. Do not take with dairy products. For women of child bearing age: advise to use reliable birth control methods while taking Malaria prophylaxis,)

_____ Malarone (Atovaquone 250 mg/Progvanil 100 mg) (Rx # ______________________________)

_____ Other (Rx # ________________________________)

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TRAVELER'S DIARRHEA PROPHYLAXIS

_____ No prophylaxis recommended

_____ Bismuth Subsalicylate (Pepto Bismol) up to 2 tabs QID
(Not to be taken with aspirin hypersensitivity, history of gout, use of anticoagulants or Hypoglycemic agents. Not recommended for children.)

_____ Probiotic

_____ Other: ____________________

SELF TREATMENT FOR TRAVELER'S DIARRHEA (H)

_____ None recommended

_____ Pepto-Bismol and Imodium AD

_____ TMP/SMX DS BID x 3-5 days (Rx # ____________________)

_____ Ciprofloxin 500 mg BID x 3 days (Rx # ____________________)
(Not with theophyiline, seizure disorder, age < 18)

_____ Levofloxacin 500 mg qd x 3 days (Rx # ____________________)
(Contraindications per cipro)

_____ Doxycycline 100 mg BID x 3 days (Rx # ____________________)
(Not with age < 18, sun exposure)

_____ Loperamide 4 mg loading, 2 mg after each unformed stool (8 mg/d max)

_____ Azithromycin 500 mg ____________________

_____ RiFaximin 200 mg q8 x 3 days

_____ Other ____________________

OTHER MEDICATIONS

_____ Acetazolamide 125 mg ____________________

_____ Diflucan 150 mg (one for yeast infection) ____________________

_____ Scopolamine patch (1.5mg), apply q3 days for motion sickness ____________________

_____ Epipen, use as directed for allergic reaction ____________________

_____ Other ____________________

OTHER RECOMMENDATIONS

____

____

HANDOUTS PROVIDED:

_____ Travel Insurance	_____ Traveler's Thrombosis	_____ Jet Lag
_____ Insect Precautions	_____ Traveler's Diarrhea	_____ Food and Beverage Precautions
_____ Safety and Security	_____ Motion Sickness	_____ Altitude Sickness
_____ Sun Protection	_____ Zika virus	_____ TRAVAX Printout

Other: ____________________ Other: ____________________

Session: Single/group for ____________ minutes.

Completed by: ____________________ Date: ____________

Reviewed history and recommendations - concur ____________________