Community Health Network

Center for International Health Travel Visit Questionnaire

Last Name _____ **First Name** _____ **Today's Date** _____

Age ____ ❑ **Male** ❑ **Female** **Date of Birth** _____ **Cell #** _____ **Home #** _____

Address _____

❑ Yes ❑ No | **Do you want us to send your primary care physician a copy of your immunization record?**

Primary Care Physician Name _____ Phone Number _____

Pharmacy Name _____ Phone Number _____

Address _____

Departure Date _____ **Return Date** _____

Destinations(s)

Country	Weeks	Country	Weeks

Check all that apply

Purpose of trip:
❑ Adventure ❑ Mission Work ❑ Teaching ❑ Volunteer
❑ Business ❑ Religious Pilgrimage ❑ Vacation ❑ Other _____
❑ Education ❑ Research ❑ Visiting Family or Friends _____

Accommodations:
❑ Cruise Ship ❑ Local Hotels ❑ Hostels ❑ Tents/Cabins
❑ First-Class Hotels ❑ Homes/Host Family ❑ Resort ❑ Other _____

Visiting:
❑ Cities ❑ Countryside ❑ Lakes ❑ Plains ❑ Other _____
❑ Towns ❑ Jungle ❑ Mountains ❑ River

Special Activities:
❑ Boating ❑ Mountain Climbing ❑ Scuba Diving ❑ Trekking
❑ Hiking/Camping ❑ Safari ❑ Swimming ❑ Other _____

❑ Yes ❑ No | **Traveling above 8000 feet (2500 meters) during trip [other than flight]:**

How did you hear about us?

❑ Previous Client
❑ Community Health Network Referral
❑ Other Health Professional (Name) _____
❑ Website
❑ Other _____

Past Medical History | Please list illnesses and surgeries:

Last Name _____ **First Name** _____

Current Medications:

Medication Name	Dose	Frequency

❑ Yes ❑ No | **Are you allergic to eggs?**

❑ Yes ❑ No | **Do you have a history of HIV?**

❑ Yes ❑ No | **Have you had disease of the thymus gland?**

❑ Yes ❑ No | **Have you had a mental health condition?**

❑ Yes ❑ No | **Chronic use of prednisone?**

❑ Yes ❑ No | **Are you immunocompromised?**

❑ Yes ❑ No | **Have you had cancer?**

❑ Yes ❑ No | **Have you had an organ transplant?**

❑ Yes ❑ No | **Have you had a bone marrow transplant?**

❑ Yes ❑ No | **Are you taking a TNF or IL-1 agent?**

Allergies

Please note medications or other substances causing an allergic reaction. Note kind of reaction for each, for example, rash, hives, shortness of breath, nausea, vomiting.

Name	Reaction	Name	Reaction

Immunization History

Immunization	Date	Immunization	Date
Hepatitis A		Rabies	
Hepatitis B		Polio	
COVID		Shingles	
Influenza		Tetanus (Td or Tdap)	
Japanese Encephalitis		Typhoid (injection)	
MMR (measles, mumps, rubella)		Typhoid (oral)	
Meningitis		Varicella (chickenpox)	
Pneumonia		Yellow Fever	

Females Only

❑ Yes ❑ No | **Are you pregnant now or is there a possibility that you might be pregnant?**

❑ Yes ❑ No | **Are you breast feeding?**