

Georgia Infectious Disease, PC
Post Travel Evaluation

Name: _____ Date of Birth _____

GAID MRN _____ Today's Date _____

Country of travel	Arrival date in Country	Departure Date	Length of Stay	Arrival in USA

What brings you to the clinic today?

Do you have any ongoing or chronic medical problems (i.e. diabetes, hypertension etc)? YES NO

If Yes please list problems:

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Geographical conditions (please check all that apply)

Savanah	
Rainforest	
Desert	
Mountians (elevation)	
Other	

Living Conditions

Major City only	
Rural Area only	
Both	

Housing (please check all that apply)

Mission Compound	
Hotel(s) (circle) 1st 2nd 3rd 4th class	
Local Dwellings	
Camping	

Invasive Procedures:

Please indicate any invasive medical prcedures you have undergone while away, and the yaer they were performed. (i.e. injections, dental or surgical)

Procedure	Year

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Please list any antibiotics or other medications, including over-the-counter medicines you took while away

Nutrition (please check all that apply)

MEALS	
Homemade	Yes No
Restaurants	Yes No
Local homes or street vendors	Yes No
Did you at any timedrink unpateurized milk or cheese	Yes No
DID YOU AT ANY TIME EAT POORLY COOKED OR RAW:	
Vegetables	Yes No
Pork	Yes No
Beef	Yes No
Seafood	Yes No
Other	Yes No
WATER SOURCE	
Tap	Yes No
Well	Yes No
Lake, River	Yes No
Bottled	Yes No
Did you drink water that was untreated or unboiled?	Yes No

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Exposure to parasitic diseases

Did/were you exposed to any of the following?

Walk barefoot	Yes No
Close contact with wild or domestic animals	Yes No
Mosquito bite	Yes No
Sandfly bite	Yes No
Tick bite	Yes No
Tsetse Fly bite	Yes No

Did you have any contact with *fresh water* from lakes, streams, or rivers for example wading, bathing, swimming, etc?

If yes, please indicate where being as specific as you can.

YES NO Location and description

Type of Travel (check all that apply)

Short Term Business (<1 month)	
Long Term Business	
Leisure	
Missionary or volunteer	

Did you receive Pre-Travel education?

YES NO

**If yes, what was your primary source of information?
(please provide contact information if possible)**

Travel Clinic		
Primary Care Provider		
Health Department		
Internet		
Other		

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Were you given information about the following?

Malaria	Yes No
Diarrhea	Yes No
AIDS/STD's	Yes No
Hepatitis A	Yes No
Hepatitis B	Yes No
Dengue fever	Yes No
Schistosomiasis	Yes No

Did you receive information about the following

Mosquito nets	Yes No
Insect Repellent	Yes No
Window/Door Screens	Yes No
Covering skin	Yes No
None	Yes No

Did you experience any of the following:

Fever for three (3) days or less	Yes No
Fever for more than three (3) days	Yes No
Diarrhea for two (2)days or less	Yes No
Diarrhea for more that two (2) days	Yes No
Diarrhea episodes 1-3	Yes No
Diarrhea episodes 4-10	Yes No
Diarrhea episodes more than 10	Yes No
Diarrhea with fever	Yes No
Diarrhea with blood stool	Yes No
Respiratory infection for less than five (5) days	Yes No
Respiratory infection for more than five (5) days	Yes No
Respiratory infection/Chest X-ray showing pneumonia	Yes No
Sinusitis	Yes No
skin infection	Yes No
Rash	Yes No
Hepatitis/Yellow jaundice	Yes No
Injuries	Yes No

