

WORLD TRAVEL CARE
 5673 Peachtree Dunwoody Road, Suite 600
 Atlanta, Georgia 30342
 Telephone 404.459.4393 FAX 404.459.4390

MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY NUMBER _____

WEIGHT (Pounds) _____ SEX (Circle) Male Female

| PAST MEDICAL HISTORY | YES | NO | DETAILS |
|--|--------------------------|--------------------------|---------|
| Do you have a medical condition that warrants maintenance medications or physician follow-up?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a medical condition that is stable now, but that might recur while traveling?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you had a fever in the past 48 hours?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Are you pregnant, or might you become pregnant on this trip?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have any stomach conditions?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a G6PD deficiency?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have bowel conditions such as diarrhea or constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had hepatitis or yellow jaundice?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a history of psychiatric problems?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a problem with strange dreams and/or nightmares?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have insomnia?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have problems with vaginitis?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have psoriasis?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a history of cardiac disease, with or without symptoms?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have any eye conditions?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Are you prone to motion sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

MEDICAL QUESTIONNAIRE PAGE TWO

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

| ALLERGIES | YES | NO | DETAILS |
|---|--------------------------|--------------------------|---------|
| ARE YOU ALLERGIC TO: | | | |
| • Any medication?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Amphotericin B?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Penicillin or Sulfa?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Mercury or thimerosal?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Polymyxin?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Sulfites?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Aluminum or aluminum hydroxide?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • 2- phenoxyethanol?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Bee stings or history of hives or urticaria?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Yeast?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Eggs?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Glycerin or chlortetracycline?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Are you hypersensitive to gelatin?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formaldehyde?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| MEDICATIONS | YES | NO | DETAILS |
|--|--------------------------|--------------------------|---------|
| ARE YOU TAKING, OR WILL YOU BE TAKING: | | | |
| • quinine, quinidine, or medications for a cardiac conduction defect?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • chloroquine, mefloquine, or proguanil to prevent malaria?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • steroids, prednisone, cortisone, or anti- cancer drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • antibiotics?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • medication to prevent traveler's diarrhea?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • antacids?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • aspirin therapy?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • medications for emotional problems?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • medication for convulsions?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • any other medications?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| IMMUNIZATIONS | YES | NO | DETAILS |
|---|--------------------------|--------------------------|---------|
| • Have you ever fainted from having your blood drawn or from an injection?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Have you ever had a fever reaction to vaccination?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Have you ever had <i>any</i> bad reaction or side effect from any vaccination?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Have you ever had hepatitis A or B vaccine?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Do you live or work closely with anyone who has AIDS, an AIDS like condition, any other immune disorder, or who is on chemotherapy for cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Do you have a family history of immunodeficiency?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| • Have you received an injection of immune globulin or any blood product during the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |