# TRAVEL MEDICINE

AT ORLANDO IMMUNOLOGY CENTER

1707 N. Mills Ave. Orlando, Fl 32803 (407) 647-3960 www.oicorlando.com

## TRAVEL QUESTIONNAIRE

Please bring ALL immunization records, and a complete list of medications with you to your visit.

**Date:** _____ **How did you hear about our center?** _____

## PERSONAL INFORMATION

Name: _____ DOB: _____
Last First Middle

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Email: _____

## TRAVEL DETAILS

| DESTINATION (city & country) | DURATION OF STAY |
|---|---|
| | |
| | |
| | |
| | |

**Date of Departure:** _____ **Length of Stay:** _____

**What is the nature of travel?**

- ☐ Living / Working or study abroad / Research
- ☐ Tourism / Leisure recreation
- ☐ Adventure Recreation (camping, trekking, rafting, contact with wild life)
- ☐ Visiting Friends or Family
- ☐ Other - Please describe purpose of trip: _____

## ACCOMODATIONS

- ☐ Cruise Ship
- ☐ Hotel / Resort
- ☐ Private Home
- ☐ Tent
- ☐ Other - Please describe purpose of trip: _____

## MEDICAL HISTORY

Active Medical Problems: _____

Date of Last Physical: _____ Prior Travel Related Illnesses: _____

Current Medications (list all, including herbal):

_____

_____

Are you Pregnant or Plan to Become Pregnant in the Next 6 Months? ☐ Yes ☐ No

Are you currently breastfeeding? (*Females Only*) ☐ Yes ☐ No

Are you an organ transplant recipient? ☐ Yes ☐ No

**DO YOU HAVE: (Check all that apply)**

___ Diabetes

___ Epilepsy (History of Seizure Disorder)

___ Cardiac Arrhythmias (irregular heart beat) or Heart Disease

___ Immune Deficiency (AIDS, cancer, steroid use)

___ History of Thymus disorders/removal

___ Psychiatric Disorders (depression, anxiety, bipolar)

___ Gastrointestinal Disorders (ulcer, spastic colon)

___ History of Myasthenia Gravis

___ Rheumatoid or psoriatic arthritis?

___ Do you have Crohn's disease

**ARE YOU ALLERGIC TO: (check all that apply)**

☐ Eggs ☐ Mercury (thimerosal) ☐ Sulfa ☐ Antibiotics

☐ Bee Stings ☐ Other: _____

Do you require an Epi-pen for any of your allergies? ☐ Yes ☐ No

## IMMUNIZATION HISTORY (if known)

| VACCINE | DATE | VACCINE | DATE |
|---|---|---|---|
| COVID -19 | | Pneumonia 23 | |
| Hepatitis A | | PPD | |
| Hepatitis B | | Polio | |
| HPV | | Rabies | |
| Influenza (Flu) | | Tetanus | |
| Japanese Encephalitis | | Typhoid | |
| Measles, Mumps, Rubella | | Varicella (Chickenpox) | |
| Meningitis | | Yellow Fever | |
| Pneumonia 13 | | Zoster (Shingles) | |

## VACCINE REACTIONS

**HAVE YOU EVER...**

Fainted or felt light-headed from a shot? ☐ Yes ☐ No

Fainted or felt light-headed from having blood taken? ☐ Yes ☐ No

Had any unusual reaction to a vaccine? ☐ Yes ☐ No

## ADDITIONAL SERVICE INTEREST

At OIC, we offer a variety of services to meet your healthcare needs. Please check any and all services you may be interested in learning more about below:

___ Traveler's Diarrhea Prevention

___ Motion Sickness Prevention

___ Nausea Prevention

___ Altitude Sickness Prevention

___ STI Prevention (Doxy-PEP)

___ HIV Prevention (PrEP)

___ Primary Care Services

___ Other Clinical Services

I certify that the above information is correct to the best of my knowledge. I understand that providing accurate information is essential for my healthcare providers to offer the best possible care and services.

_____ _____

Patient Signature Patient Name (Print)