

Tulane Travel Clinic
PRE-TRAVEL QUESTIONNAIRE

Please try to have this form completed when you come for your visit. It will speed up the visit & help to serve you better.

Name: _____ Date: _____
SS#: _____

Address: _____

Phone: (H) _____ (o): _____
©: _____ e-mail _____

Date of Birth: _____

Where attended elementary school (city, state): _____

Where attended high school (city, state): _____

Referred by: _____

Departure date: _____ Return date: _____

Date of departure from New Orleans: _____

ITINERARY:

Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___
Country _____	Duration _____	Rural ___	Urban ___

PREVIOUS TRAVEL:

Country _____	Dates _____	Rural ___	Urban ___
Country _____	Dates _____	Rural ___	Urban ___
Country _____	Dates _____	Rural ___	Urban ___
Country _____	Dates _____	Rural ___	Urban ___

PURPOSE of upcoming travel (check all that apply):

___ Leisure ___ Business ___ Volunteer ___ Medical Work
___ Visiting friends or family ___ Other (describe) _____

ALLERGIES (medicines, foods, environmental factors, stings):

1. _____
2. _____
3. _____
4. _____

PRE-TRAVEL QUESTIONNAIRE (con't)

PAST MEDICAL HISTORY

Do you have any of the following:

	Yes	No	Details
Heart disease	___	___	_____
Lung disease (i.e. asthma)	___	___	_____
High blood pressure	___	___	_____
Diabetes	___	___	_____
Psoriasis	___	___	_____
Hepatitis	___	___	_____
Seizures/ epilepsy	___	___	_____
Blood clots	___	___	_____
Depression	___	___	_____
Other psychiatric problem	___	___	_____
Other medical problem	___	___	_____
Recent surgery	___	___	_____

Please list any medicines you take regularly or frequently, including over the counter

Do you wear contact lens? Yes ___ No ___

Are you pregnant or might you become pregnant during your travel? Yes ___ No ___

Do you have or are you at risk for immune deficiency or HIV infection? Yes ___ No ___

Have you had chicken pox disease? Yes ___ No ___

PRIOR IMMUNIZATIONS (Please give dates & bring all documentation if possible):

_____ Diphtheria	_____ Meningococcal vaccine
_____ Tetanus	_____ Polio
_____ Pertussis	_____ Rabies
_____ Hepatitis A	_____ Typhoid
_____ Hepatitis B	_____ Yellow fever
_____ Japanese encephalitis	_____ Cholera
_____ Measles	_____ Pneumococcal
_____ Mumps	_____ Influenza
_____ Rubella	_____ Other

ACCOMODATIONS (check all that apply):

Hotel: First class _____ Private home _____ Resort _____
Economy _____ Camping _____ Youth hostels _____
Safari: _____

ACTIVITIES PLANNED (check all that apply):

___ Scuba diving ___ Hiking or trekking ___ Biking
___ High altitude visit ___ High altitude climbing ___ Medical work