MURPHY'S TRAVEL HEALTH CLINIC
TRAVEL QUESTIONNAIRE

Name: ____________________
Date of Birth: ____________________
Health Card Number: ____________________
Weight: ____________________
Address: ____________________
Phone: (H) __________ (W) __________
(C) __________ Email: __________

TRAVEL ITINERARY

Date of Departure: ____________________
Length of Stay: ____________________
Purpose of Trip: Business ☐ Pleasure ☐
Type of Accommodations: (i.e. hotel, resort, ship):
____

Which countries will you visit?
1st. ____________________
2nd. ____________________
3rd. ____________________
4th. ____________________

Activities planned(i.e. hiking water sports): ____________________
____

Allergies (including insects):
1st. ____________________
2nd. ____________________
3rd. ____________________
4th. ____________________

Are you pregnant? Yes ☐ No ☐
Are you breastfeeding? Yes ☐ No ☐

Please mark a check if you have any of the following conditions:

Asthma	☐	High Blood Pressure	☐
Bleeding Disorders	☐	HIV/AIDS	☐
Bronchitis	☐	Immune Deficiencies	☐
Cancer	☐	Kidney Problems	☐
Diabetes	☐	Mental Disorders	☐
Eczema	☐	Psoriasis	☐
Emphysema	☐	Removal of Spleen	☐
Epilepsy/Seizures	☐	Stomach Disorders	☐
Heart Problems	☐	Ulcers	☐
Hepatitis/Jaundice	☐		☐

If not listed please specify: ____________________
____

Please list all medications and supplements that you are currently taking:
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Summary of immunization history:
DPT/TD: Yes ☐ No ☐
Last Booster: __________ (Less than 10 year)
Polio: Yes ☐ No ☐
Last Booster: __________ (Less than 10 year)
MMR/Varicella: Yes ☐ No ☐
Last Booster: __________ (Less than 10 year)
Hepatitis A: Yes ☐ No ☐
1. __________ 2. __________
Hepatitis B: Yes ☐ No ☐
1. __________ 2. __________ 3. __________
Yellow Fever: Yes ☐ No ☐
Date: __________ (Less than 10 year)
Typhoid Fever: Yes ☐ No ☐
Date: __________ (Less than 10 year)
Rabies: Yes ☐ No ☐
Date: __________
Meningitis: Yes ☐ No ☐
Date: __________
Influenza Viral: Yes ☐ No ☐
Date: __________
Pneumovax 23: Yes ☐ No ☐
Date: __________

Have you had any problems with any of these immunizations in the past? Yes ☐ No ☐
If yes please specify: ____________________

Please mark a check if you have experienced any of the following travel issues:

Nausea	☐	Insomnia	☐
Rashes	☐	Vomiting	☐
Weakness	☐	Insect Bites	☐
Diarrhea	☐	Sunburn	☐
Parasites	☐	Other: __________	

____

Please fill out this questionnaire prior to appointment.