



Good Samaritan Occupational Health
375 Dixmyth Avenue
513-862-2875
513-862-2860 (fax)

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____ Sex: _____

Employer: _____ Phone (H): _____ (W) _____

Itinerary Planned (list below) Date of Departure: _____

Table with 3 columns: Country/City, Duration of Stay, Rural or Urban Areas. Rows 1-8.

(Continue on back if more countries need to be listed)

Date returning to USA: _____ Total length of trip: _____

Do you plan on having any recreational activities outside of normal tourist areas such as hiking, climbing, swimming, boating, etc? [] Yes [] No

If yes, please explain: _____

Have you ever traveled outside of the USA before? [] Yes [] No
If yes, did you have any health problems? Explain: _____

Do you take medication? [] Yes [] No
If yes, please list here: _____

Do you have any allergies, including medications, animals, foods, insects, plants, etc?

Yes No

If yes, please explain: _____

Do you have any current health problems which you are either treating yourself or under the care of a physician? Yes No

If yes, please explain: _____

Have you ever had any serious health problem in the past, including the need for surgery?

Yes No

If yes, please explain: _____

Do you have any problems with travel such as motion sickness, ear problems, jet lag, etc?

Yes No

If yes, please explain: _____

Did you receive childhood vaccinations that would have been considered routine when you were a child such as polio, measles, mumps, diphtheria, Pertussis, Rubella, Tetanus, etc?

Yes No Unsure

If yes, please explain: _____

Have you ever had a bad reaction to a vaccine? Yes No

If yes, please explain: _____

When was your last tetanus booster shot? _____

Is there a chance you may be pregnant? Yes No

Do you live with anyone that has a suppressed immune system? Yes No

Please indicate any vaccinations that you know for certain (from military records, personal medical records, travel records, childhood vaccination records, etc.) that you have received:

- Tetanus
- Influenza
- Polio
- Measles
- Mumps
- Rubella

- Chicken pox
- Diphtheria
- Pertussis
- Hepatitis A
- Hepatitis B
- Typhoid

- Cholera
- Yellow Fever
- Japanese Encephalitis
- Meningococcal
- Rabies
- Pneumococcal

Have you ever taken medication to prevent Malaria? Y N

If yes, date taken: _____ List any side effects: _____

Will your work or travel put you at risk for exposure to animals such as dogs? Yes No

If yes, please explain: _____

Will your work or travel put you at risk for exposure to human body fluids? Yes No

If yes, please explain: _____

Do you need information about/food and water safety? Yes No

Do you need information about insect protection? Yes No

Do you need information about jet lag? Yes No

Do any of the countries you are to visit require any special medical certificate of health?

Yes No

If yes, please explain: _____

Comments: _____

Signatures:

Traveler

Physician/Nurse

Date

Date