Government of Bermuda
Department of Health (DOH)

TRAVEL MEDICINE SERVICE
Trip Planning Questionnaire

***Travelers**: at the beginning of each new trip, please answer the questions on this sheet as best as you can. It will help us to help you.*

FIRST NAME	MIDDLE INITIAL(S)	LAST NAME	Gender
			MALE ☐ FEMALE ☐

ADDRESS	DATE OF BIRTH (*dd/mm/yyyy*)	AGE (*years*)

EMAIL	TELEPHONE: Work	TELEPHONE: Home

HAVE YOU ATTENDED THE TRAVEL HEALTH CLINIC PREVIOUSLY? If Yes, in what year?	TELEPHONE: Cell
☐ Yes ☐ No _____	

Where are you going? - ITINERARY
(List countries and dates, in order of travel)

DEPARTURE DATE	RETURN DATE

TOTAL LENGTH OF TRIP

_____Days _____Weeks _____Months _____Years

Country 1	*Duration (days)*	*Rural or Urban*
Country 2	*Duration (days)*	*Rural or Urban*
Country 3	*Duration (days)*	*Rural or Urban*
Country 4	*Duration (days)*	*Rural or Urban*

PURPOSE OF TRAVEL

Business ☐
Vacation ☐
Mission/Disaster Relief ☐
Sports/other Recreational Activity ☐

WHERE WILL YOU STAY:

Hotel/Resort ☐
Private Home ☐
Safari/Camp-site ☐
Youth Hostel ☐
Cruise Ship ☐
_____Other ☐

WHAT KIND OF TRAVELLER ARE YOU?

Travelling with young children ☐
Have a chronic disease *(e.g. heart disease, diabetes)* ☐
Passenger on a Cruise Ship ☐
Extended Stay *(over 30 day* or Study Abroad ☐
Immune-compromised Traveler *i.e. with cancer or other illness, or taking drugs that reduce immunity)* ☐
Pregnant Woman ☐
Visiting Friends or Family ☐
_____**Other** ☐

PERSONAL MEDICAL HISTORY

Do you have a history of significant medical conditions? Yes ☐ No ☐

If Yes, do you have:
Hepatitis ☐
Psoriasis, Lupus or Rheumatoid Arthritis ☐
Seizure Disorder/Epilepsy ☐
Heart rhythm problems ☐
Mental Health Problems ☐
Renal (Kidney) Problems ☐
Thyroid Problems ☐
Any condition not mentioned above ☐

Please list <u>ALL</u> other medical conditions

_____

_____

Are you currently taking any medications? Yes ☐ No ☐

If Yes, do you take:
Quinidine ☐
Digoxin ☐
Calcium Channel Blockers (*Verapamil*) ☐
Beta-blockers (*e.g. Inderal*) ☐
Any other heart medications ☐
Anti-seizure medication ☐
Anti-coagulants (*Coumadin/Warfarin*) ☐
Medication(s) not mentioned above ☐

Please list <u>ALL</u> other medications

_____

_____

IMMUNIZATION HISTORY

√ RECEIVED	REACTION Y/N
☐ Diphtheria/Tetanus	Yes / No
☐ Tetanus/diphtheria/pertussis (Tdap)	Yes / No
☐ Typhoid	Yes / No
☐ Cholera	Yes / No
☐ Yellow fever	Yes / No
☐ Measles/Mumps/Rubella	Yes / No
☐ Hepatitis A	Yes / No
☐ Hepatitis B	Yes / No
☐ Immune Globulin	Yes / No
☐ Meningococcal	Yes / No
☐ Polio	Yes / No

If YES to any, describe_____

Do you have any condition that affects your immune system? Yes ☐ No ☐

<u>For Women</u>: Date of your last menstrual period: _____

Are you pregnant or currently trying to become pregnant? Yes ☐ No ☐

Are you allergic to any drugs, vaccines or food *(e.g. eggs or chicken products)*? Yes ☐ No ☐

List Allergies: _____

_____

TODAY'S DATE		TRAVELLER'S SIGNATURE	

TRAVEL MEDICINE SERVICE

TO BE COMPLETED BY DOH STAFF ONLY
Prophylaxis and/or Vaccines

Required		Recommended/Routine	
Typhoid	☐	Influenza	☐
Cholera	☐	Hepatitis A	☐
Yellow Fever	☐	Hepatitis B	☐
Japanese Encephalitis	☐	MMR	☐
Rabies	☐	Meningococcal	☐
Tick-borne Encephalitis	☐	Polio	☐
Malaria	☐	Tdap/Td	☐

Additional Comments

Health Care Provider Objective Review & Assessment

Have you reviewed the Personal Medical History, as reported on Trip Planning Questionnaire? *YES* ☐ *NO* ☐

PLANNED IMMUNIZATIONS & PROPHYLAXIS (Physician to complete this section)

Tetanus/Diphtheria (Td) ☐ _____
Tetanus/Diphtheria/Acellular Pertussis (TdaP) ☐ _____
Typhoid ☐ _____
Meningococcal Vaccine ☐ _____
Polio ☐ _____
Measles/Mumps/Rubella (MMR) ☐ _____
Hepatitis B #1 ☐ _____
Hepatitis B #2 ☐ _____
Hepatitis B #3 ☐ _____
Yellow Fever ☐ _____
Hepatitis A #1 ☐ _____
Hepatitis A #2 ☐ _____

Cholera ☐ _____
Jap. Enceph.#1 ☐ _____
Jap. Enceph.#2 ☐ _____
Influenza ☐ _____
Rabies #1 ☐ _____
Rabies #2 ☐ _____
Rabies #3 ☐ _____
Varicella ☐ _____
Other ☐ _____
Other ☐ _____

Malaria Rx ☐ _____

PHYSICIAN'S SIGNATURE	DATE