CHATTANOOGA-HAMILTON COUNTY
HEALTH DEPARTMENT
CHATTANOOGA, TN

PLACE PAL LABEL HERE

PRE-TRAVEL HEALTH SCREEN

Today's Date: ___/___/____

TRAVEL INFORMATION	Comments/Description

Departure Date: ___/____/______

Length of Stay: ______days/weeks/months/years

Reason for Travel (circle choice(s)): Business/Education/School/Leisure/ Mission/Other: ______________________________

Destination and travel itinerary (list countries in order of travel): ____

Planned activities (please circle all that apply): hiking / climbing / diving / other water sports / camping / construction / caring for children of others

Cruising / sightseeing via public transportation / other: ____

GENERAL MEDICAL	NO	YES	DESCRIBE
Do you have a medical condition that you regularly take medications for or see a physician?			
Have you had an acute illness or fever in the past 48 hours?			
(Females only) Last Menstrual Period			
(Females only) Are you pregnant/breastfeeding or do you plan to become pregnant in the near future?			
Do you have any stomach or intestinal conditions?			
Do you have any other chronic health problems?			
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, Guillain Barre Syndrome or brain infection or take medicine for any of these?			
Have you ever been diagnosed with a thymus disorder, such as myasthenia gravis, thymoma or DiGeorge Syndrome?			
Do you have an immune deficiency disorder, such as leukemia, cancer or AIDS? Are you taking any immune suppressing drugs or are you post-transplant?			
Are you being treated for rheumatoid arthritis, Crohn's Disease or any other condition with an antimetabolite (like Remicade, Enbrel, Methotrexate or Humira)?			
Do you live or work closely with anyone who has AIDS, an AIDS-like condition, any other immune disorder or who is on chemotherapy for cancer?			
Do you have a bleeding disorder?			

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PRE-TRAVEL HEALTH SCREEN (Continued)

IMMUNIZATIONS	NO	YES	DESCRIBE
Have you received any immune globulin or blood product(s) during the past 12 months?			**WHAT?**
Have you ever had a fever/bad reaction/side effect to a vaccine?			
Have you ever fainted from getting an injection?			
Have you had the measles or the vaccine?			**WHICH?**
Have you ever received Yellow Fever vaccine before?			**WHEN?**
Have you received any antivirals, TB skin tests or other vaccines in the last 4 weeks?			**WHAT?**

Are you allergic to any foods, medicines or latex? □ No □ Yes, please list ____________________________________

ARE YOU ALLERGIC TO:	NO	YES	REACTION
Penicillin/sulfa?			
Mercury/thimerosal/formaldehyde?			
Gentamicin/streptomycin/neomycin/polymixin?			
Yeast/eggs/chicken protein/beef protein?			
Aluminum/aluminum hydroxide/hydrocortisone?			
2-phenoxyethanol/EDTA/ arginine?			
Are you hypersensitive to soy, gelatin or lactose?			
Bee/wasp stings?			
Other:			

ARE YOU TAKING OR WILL YOU BE TAKING:	NO	YES	WHAT and WHY?
Antacids/Pepto-Bismol?			
Proguanil for preventing malaria?			
Steroids, prednisone or anti-cancer drugs?			
Heart medications?			
High blood pressure medications?			
Antibiotics or sulfonamides?			
Oral contraceptives?			
Aspirin therapy?			
Any blood thinner?			
Other medications, including herbals and over the counter medicines- please list:			

I, ___________________________________(print name) as the patient or the parent/guardian of the patient certify that the above information is accurate.

Date: __________ Signature: __________________________________ Witness: _____________________________

Reviewing nurse signature: ____