

# North Shore Medical Associates, p.c.

*Travel Medicine Services*

107 Northern Blvd., Suite 206  
Great Neck, NY 11021

www.doctormelgar.com

Telephone (516) 829-2016

*Michael J. Melgar, MD*

Fax (516) 829-2019

## Traveler's Health Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please answer all questions to the best of your ability.

List all cities/countries you are traveling to and the arrival and departure dates for each on the next page.

### Why are you traveling?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Leisure                 | <input type="checkbox"/> Adventure              | <input type="checkbox"/> Business               |
| <input type="checkbox"/> Visiting Family/Friends | <input type="checkbox"/> Military               | <input type="checkbox"/> Airline crew           |
| <input type="checkbox"/> Expedition              | <input type="checkbox"/> Extended travel abroad | <input type="checkbox"/> International Adoption |
| <input type="checkbox"/> Missionary work         | <input type="checkbox"/> Peace Corps            |   |

### Do your plans include:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Excursions                        | <input type="checkbox"/> Safaris              | <input type="checkbox"/> Handling Animals                  |
| <input type="checkbox"/> Swimming or wading in fresh water | <input type="checkbox"/> Trips to rural areas | <input type="checkbox"/> Sexual activity with local people |

List all chronic medical conditions you have ( ie. Blood pressure, diabetes, heart disease, cancer, asthma, etc).

- |         |          |
|---------|----------|
| 1 _____ | 6 _____  |
| 2 _____ | 7 _____  |
| 3 _____ | 8 _____  |
| 4 _____ | 9 _____  |
| 5 _____ | 10 _____ |

### Please list all medications you are currently taking.

Medication	Dose	Times/day	Medication	Dose	Times/Day
1 _____	_____	_____	7 _____	_____	_____
2 _____	_____	_____	8 _____	_____	_____
3 _____	_____	_____	9 _____	_____	_____
4 _____	_____	_____	10 _____	_____	_____
5 _____	_____	_____	12 _____	_____	_____
6 _____	_____	_____	13 _____	_____	_____

### Do you have any allergies to:

- |  |   |
|--|---|
| <input type="checkbox"/> Medications _____ | <input type="checkbox"/> Insect bites _____ |
| <input type="checkbox"/> Vaccines _____    | <input type="checkbox"/> Foods/Eggs _____   |

**When did you last receive the following vaccines: Approx year, “childhood”, or never is OK**

<input type="checkbox"/> Tetanus/ Diphtheria	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Influenza	_____	<input type="checkbox"/> Measles/Mumps/Rubella	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> Typhoid	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Yellow Fever	_____

**Women patients only. Check all that apply**

<input type="checkbox"/> Currently Pregnant / due date _____	<input type="checkbox"/> Planning to get pregnant in next 3 months
<input type="checkbox"/> Breast feeding	<input type="checkbox"/> Frequent Urinary tract infections?

Dates of travel Leaving \_\_\_\_\_ Returning \_\_\_\_\_

Destination (List all cities /countries that will be visited and approximate dates)

\_\_\_\_\_  
City / Country From/To

\_\_\_\_\_  
City / Country From/To

\_\_\_\_\_  
City / Country From/To

\_\_\_\_\_  
City / Country From/To

\_\_\_\_\_  
City / Country From/To