



Family Travel Clinic Pre-Travel Health Questionnaire

Please complete one form for each traveler. If you are completing this form for a child, answer the questions for the child. If you are unsure of an answer, write “unsure”.

Traveler Information

Date form completed	
First name	
Last name	
Date of birth	DD / MM / YYYY
Child's current weight	_____ kg or _____ lbs

Travel Plans

Date leaving home	
Date returning home	

Itinerary — Please include all countries, cities or regions, stopovers, order of travel and how long you will stay in each place.

City / region	Country	Number of days	Stopover?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Trip Details

Type of destination	☐ City/urban ☐ Rural ☐ Remote ☐ High altitude ☐ Beach ☐ Jungle/forest
Is your itinerary fixed?	☐ Yes ☐ No ☐ Unsure
Purpose of travel	☐ Vacation ☐ Visiting friends/family ☐ Business ☐ School/study ☐ Volunteer/humanitarian ☐ Medical care ☐ Adoption ☐ Cruise ☐ Religious/pilgrimage ☐ Other: _____
Are you traveling with an organized tour?	☐ No ☐ Yes Tour company/name: _____
Accommodation	☐ 2-3 star hotel ☐ 4-5 star hotel ☐ Hostel ☐ Staying with family/friends ☐ Rental home/apartment ☐ Camping ☐ Cruise ship/boat ☐ Safari ☐ Other: _____
Will you be traveling alone?	☐ Yes ☐ No If no, who is travelling with you? _____

Planned Activities

Check all activities you may do during your trip.

☐ Air travel	☐ Biking	☐ Hiking/trekking
☐ Swimming in freshwater	☐ Swimming in salt water	☐ Snorkeling/scuba
☐ Rafting/boating	☐ Contact with animals	☐ Caves/spelunking
☐ Public transportation	☐ Motorcycle/scooter	☐ Visiting schools, hospitals or orphanages
Other activities: _____		

Medical History

Please answer yes or no. If you answer "yes," please add details in the space provided.

Question	Answer	Details
Do you take medication regularly?	☐ Yes ☐ No	
Are you currently under the care of a physician or specialist?	☐ Yes ☐ No	
Have you had surgery, hospitalization, blood transfusion or blood products in the past 5 years?	☐ Yes ☐ No	
Have you ever had hepatitis or liver disease?	☐ Yes ☐ No	
Has your spleen been removed?	☐ Yes ☐ No	

Have you had a positive TB test?	☐ Yes ☐ No	Date of positive:
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Conditions That May Affect Travel Vaccines or Medications

Condition or history	Answer	Details
Seizures or convulsions	☐ Yes ☐ No	
Heart disease, heart surgery, pacemaker or rhythm problem	☐ Yes ☐ No	
Lung or breathing condition	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Immune system problem or treatment that weakens the immune system	☐ Yes ☐ No	
Live or work closely with someone who has a weakened immune system	☐ Yes ☐ No	
Thymus gland condition or thymus surgery	☐ Yes ☐ No	
History of altitude illness	☐ Yes ☐ No	
History of tendonitis or Achilles tendon rupture	☐ Yes ☐ No	
Depression, anxiety, panic attacks or psychiatric medication use	☐ Yes ☐ No	
Other medical concerns/chronic health conditions	☐ Yes ☐ No	

Allergies

Allergy type	Answer	Reaction / details
Medication	☐ Yes ☐ No	
Vaccine reaction	☐ Yes ☐ No	
Egg or food allergy	☐ Yes ☐ No	
Environmental allergy, including pollen, dust, hay fever, asthma or iodine	☐ Yes ☐ No	
Animal allergy	☐ Yes ☐ No	
Bee sting allergy	☐ Yes ☐ No	
Have you ever had anaphylaxis/a severe allergic reaction?	☐ Yes ☐ No	

Medications and Supplements

Please list all prescription medications, over-the-counter medications, vitamins, natural products and supplements.

Medication or supplement	Dose	How often?	Reason for use

Vaccine History

Please check what you know. If you have a vaccine record, please attach it or bring it to your appointment.

Vaccine or infection	Yes	No	Unsure	Date(s), if known
Tetanus/diphtheria/pertussis	☐	☐	☐	
Measles, mumps and rubella	☐	☐	☐	
Chickenpox/varicella vaccine or illness	☐	☐	☐	
Influenza	☐	☐	☐	
COVID-19	☐	☐	☐	
Hepatitis A	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Twinrix	☐	☐	☐	
Polio-childhood series	☐	☐	☐	
Polio-adult booster or dose				
Meningococcal	☐	☐	☐	
Typhoid (IM)	☐	☐	☐	
Typhoid (oral)				
Yellow fever	☐	☐	☐	

Rabies	☐	☐	☐	
Japanese encephalitis	☐	☐	☐	
HPV				
Pneumococcal –e.g. PPV, Prevnar,				
Meningitis B- e.g. bexsero				
Other vaccines				

Pregnancy and Breastfeeding/Chest-feeding

Complete this section if applicable.

Are you pregnant or trying to become pregnant?	☐ Yes ☐ No ☐ Unsure ☐ Not applicable
Are you breastfeeding/chest-feeding?	☐ Yes ☐ No ☐ Not applicable