JUPITER MEDICAL CENTER

OCCUPATIONAL HEALTH SERVICES AT URGENT CARE
5430 Military Trail, Ste 64, Jupiter, FL 561-263-7010 Fax 561-776-3998

TRAVEL VACCINE QUESTIONNAIRE

Name: _____DOB: _____

Address_____

_____

Phone # _____Email _____

Gender ☐Male ☐Female Country of Birth _____

Counties Traveling to (In order of travel) *Note specific regions or cities*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Departure Date_____ Length of Stay_____

Visiting Family or friends? _____ Location _____

Animal Contact on Trip? _____

Adventurous Dietary Habits? _____

Cruise ☐Yes ☐No	Safari ☐Yes ☐No	Swimming ☐Yes ☐No
Diving ☐Yes ☐No	Hiking ☐Yes ☐No	Rafting ☐Yes ☐No
Biking ☐Yes ☐No	Camping ☐Yes ☐No	Cave Exploring ☐Yes ☐No

OTHER _____

Reason for Travel _____

Health Care Worker or Volunteer?_____

Solo Traveler? _____

Past immunizations? _____

Allergies to any medications? _____

Current Medications? _____

Allergies to any foods? _____

Medical history_____

_____

Women only:

Are you pregnant or might you become pregnant on the trip? ☐Yes ☐No

Date of last menstrual period: _____

HIGH RISK TRAVELERS

On your trip will you Take part in the following activities:

Acupuncture ☐Yes ☐No Tattoo ☐Yes ☐No Surgery ☐Yes ☐No

Dental Work ☐Yes ☐No Drug Use ☐Yes ☐No New Sexual Partner ☐Yes ☐No

Signature of Traveler _____ Date _____

Approved Medical Director_____ Date_____

Travel Nurse _____ Date_____