PRE-TRAVEL ASSESSMENT

Weill Cornell Travel Medicine

1305 York Av., 4th floor, New York NY 10021,
Phone 646 962 4800, Fax 646 962 0152

Name: _____ DOB_____ Age____
Last, First

Address: _____

_____

Gender: ❑ Male ❑ Female Current weight_____

Primary care physician: _____

Were you referred by a physician /friend/travel agent? _____
If yes, please list name and contact info: _____

Travel Details

Departure date: _____ Return date: _____

Duration of travel: _____

Itinerary (locations in chronological order):

	Urban	Rural
1._____	❑	❑
2._____	❑	❑
3._____	❑	❑
4._____	❑	❑
5._____	❑	❑

Anticipated Exertion during the trip

Minimal ❑ Moderate (long walks, hiking) ❑ Heavy (climbing, sports) ❑
High altitude (>10,000 ft) ❑ Trekking ❑ Diving ❑ White Water Rafting ❑

Immunization Related Questions

1. Are you currently pregnant YES❑ No❑ (If yes, please **ALERT** provider)
2. Are you planning to become pregnant within the next 3 months? Yes❑ No❑
3. Have you ever had a seizure, depression, anxiety disorder, etc.? Yes❑ No❑
4. Do you NOW have a fever, sore throat or flu-like symptoms? Yes❑ No❑
5. Do you, or any household member receive any immunosuppressive drugs? (steroids, anti-cancer-, anti-rheumatoid arthritis meds)? Yes❑ No❑
6. Are you infected with HIV or do you have AIDS? Yes❑ No❑
7. Are there other reasons why your immune system is weakened? Yes❑ No❑

Current Active Medications (write NONE if no medications):

	Name of medication	Purpose/Indication
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

Allergies (mark all that apply):

none ❑

Sulfa drugs	❑	Vaccines	❑
Penicillin	❑	Chicken eggs	❑
Latex	❑	Thimerosal	❑
Neomycin	❑		

Other medication allergies: _____

Past Medical History

Diabetes mellitus	Yes❑	No❑	Splenectomy	Yes❑	No❑
Tobacco use	Yes❑	No❑	Alcohol	Yes❑	No❑
Bleeding disorder	Yes❑	No❑	Sickle Cell Disease	Yes❑	No❑
Lupus	Yes❑	No❑	Skin Disease	Yes❑	No❑
Rheumatoid Arthritis	Yes❑	No❑	Stomach/Intestinal Dis.	Yes❑	No❑
Heart Disease	Yes❑	No❑	History of tendon rupture	Yes❑	No❑
Chronic Kidney Disease	Yes❑	No❑	Cancer history	Yes❑	No❑
Chronic Liver Disease	Yes❑	No❑	If yes, specify: _____		
Chronic Lung Disease	Yes❑	No❑	_____		

Other relevant past medical history: _____

_____

SIGNATURE: _____

Today's Date: _____