PRE-TRAVEL ASSESSMENT

Weill Cornell Travel Medicine

1305 York Av., 4th floor, New York NY 10021,
Phone 646 962 TRIP (8747), 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 known ☐

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 Abuse	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: _____