Sample pretravel risk assessment questionnaire

Patient age: _____ **Gender:** ◯ Male ◯ Female

Medical History

Does the patient have or has he/she had any of the following?

- ◯ Diabetes mellitus
- ◯ Chronic cardiac condition; please specify: _____
- ◯ Chronic pulmonary condition; please specify: _____
- ◯ Renal disease
- ◯ Mental health/psychiatric illness; please specify: _____
- ◯ Thymus disorder (e.g., myasthenia gravis, DiGeorge syndrome, thymoma)
- ◯ HIV, AIDS, immune deficiency, or other immune disorder; please specify: _____
- ◯ Leukemia, cancer; please specify: _____
- ◯ Radical mastectomy or lymph-node dissection
- ◯ Convulsions, seizures, epilepsy
- ◯ Blood or clotting disorder

Is the patient pregnant or breastfeeding or does she plan on becoming pregnant on this trip or soon afterwards?

◯ Yes ◯ No

Is the patient allergic to any of the following?

◯ Sulfa drugs ◯ Penicillin ◯ Yeast ◯ Gelatin
◯ Streptomycin, gentamicin, neomycin ◯ Latex ◯ Eggs or other foods: _____

Medications

Is the patient on any of the following or has he she/taken any of these medications in the last 3 months?

- ◯ Blood thinners (e.g., warfarin, clopidogrel)
- ◯ Corticosteroids
- ◯ Chemotherapy or other anti-cancer medications; please specify: _____
- ◯ Quinine, quinidine or other cardiac drugs; please specify: _____
- ◯ Antibiotics; please specify: _____
- ◯ Medications for mood disorders or emotional problems; please specify: _____
- ◯ Medications to control seizures or convulsions; please specify: _____
- ◯ Any other prescription medication not indicated above; please specify: _____

Travel History

List countries/regions that the patient has visited in the past:

_____
_____
_____
_____
_____

List any significant health outcomes/medical issues during this previous travel:

_____
_____
_____
_____
_____

Current Itinerary Details

Date of Departure: _____ **Duration of Trip:** _____

List all countries/cities (in order) that the patient will be visiting (including transit stops):

Country 1: _____ City/Region: _____ Duration of stay: _____
Country 2: _____ City/Region: _____ Duration of stay: _____
Country 3: _____ City/Region: _____ Duration of stay: _____
Country 4: _____ City/Region: _____ Duration of stay: _____
Country 5: _____ City/Region: _____ Duration of stay: _____

Are there any recent travel advisories/outbreaks in these countries? If yes, please list:

_____

Is there access to appropriate medical care in these countries? Please explain:

_____

Is the patient a last-minute traveller? ◯ Yes ◯ No

Is the patient travelling:

◯ Alone? ◯ With spouse/partner? ◯ With a group? ◯ With Children? ◯ With older/elderly persons?

What is the purpose of the travel?

◯ Pleasure/recreation ◯ Study ◯ Business ◯ Adventure ◯ Medical work
◯ Visiting friends and relatives (VFRs) ◯ Missions/humanitarian/relief/volunteer
◯ Other: _____

During travel, will the patient be:

◯ Hiking/trekking? ◯ Caving? ◯ Rafting/kayaking? ◯ In contact with animals?
◯ Spending time on a farm? ◯ At altitudes >2500 m? ◯ Scuba diving?

Where is the patient going to stay during his/her travels (i.e., urban vs. rural areas, types of accommodations, living conditions)?

_____

Which mode(s) of transportation will the patient be using (e.g., train, in-country flights, car, boat, motorbike, etc.)?

_____

Does the patient have travel health/repatriation insurance? ◯ Yes ◯ No

If the patient is deemed to be a high-risk traveller based on this risk assessment (see criteria in Figure 1), please refer to a travel medicine clinic/professional in your area

Referral Recommendation:

Physician: _____ Travel Clinic: _____
Address: _____
Phone: _____ Email: _____

Please ensure patient brings a copy of this completed questionnaire to their referral appointment.

Adapted from the International Travel Medical Questionnaire developed by Dr. D. Cherniwchan