Jefferson.
University Hospitals

Pre-Travel Needs Assessment

Name

Date

Address

Home Phone | Work Phone | Birth Date | Age | Sex

Cell Phone | Name of Emergency Contact | Emergency Phone Number

List all countries/geographical regions to be visited during current trip:

Date of Departure | Date of Return

Purpose of Travel (check one)

☐ Business ☐ Field Work ☐ Vacation ☐ Foreign Study ☐ Missionary ☐ Other ____________

Type of Travel (check one)

☐ Guided Escort Tour ☐ Independent Travel – fixed itinerary ☐ Independent Travel – flexible itinerary

Accommodations (check all that apply)

☐ Hotel ☐ Resort ☐ Private Home ☐ Safari ☐ Camp ☐ Hostel ☐ Other____________

General Medical

	Yes	No
1. Have you had a splenectomy (spleen removed)?	☐	☐
2. Do you have a medical condition that is stable now, but that may recur while traveling?	☐	☐
3. Are you pregnant or nursing (breast feeding) or might you become pregnant on this trip?	☐	☐
4. Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia or cancer?	☐	☐
5. Have you ever had a convulsion, seizure, epilepsy, or neurologic condition?	☐	☐
6. Do you have any stomach conditions?	☐	☐
7. Do you have a G6PD deficiency?	☐	☐
8. Do you have bowel conditions such as diarrhea or constipation?	☐	☐
9. Have you ever had hepatitis or yellow jaundice?	☐	☐
10. Do you have a history of depression?	☐	☐
11. Do you have a problem with strange dreams and/or nightmares?	☐	☐
12. Do you have insomnia?	☐	☐
13. Cardiac disease, with or without symptoms?	☐	☐
14. Do you have any eye conditions?	☐	☐
15. Are you prone to motion sickness?	☐	☐

Current Medical Conditions/Medical and Surgical History

Current Medications (include over the counter and alternative therapies)

Allergies

Are you allergic to:	Yes	No
• any medications?	☐	☐
• penicillin or sulfa?	☐	☐
• mercury or thimerosal?	☐	☐
• latex?	☐	☐

Are you allergic to:	Yes	No
• Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)	☐	☐
• polymyxin?	☐	☐
• sulfites?	☐	☐

Are you allergic to:	Yes	No
• aluminum or aluminum hydroxide?	☐	☐
• bee stings or history of hives or urticaria?	☐	☐
• yeast?	☐	☐
• eggs?	☐	☐

Form 4292-NS (Rev. 01/09) ©2013 Thomas Jefferson University Hospitals. All rights reserved.

Pre-Travel Needs Assessment

Prior Immunizations/Vaccinations

Immunizations/Vaccinations	Dates	# of Doses	Immunizations/Vaccinations	Dates	# of Doses
Diphtheria, Tetanus, Pertussis (DTaP or DTP)			Meningococcal meningitis		
Hepatitis A			Pneumococcal (conjugate or polysaccaride)		
Hepatitis B			Poliomyelitis, primary series		
Hepatitis A/ Hepatitis B combined			Polio booster		
H. influenzae type b (Hib)			Rabies (vaccine or IG)		
Hib/DTaP or Hib/DTP			Tetanus, Diphtheria (Td) if > 7 years of age		
Hib/Hepatitis B			Typhoid fever (oral/IM)		
Influenza			Varicella (chicken pox)		
Japanese encephalitis			Yellow fever		
Measles, Mumps, Rubella			Other:		

Immunizations

	Yes	No
• Have you ever fainted from having your blood drawn or from an injection?	☐	☐
• Have you ever had a fever reaction to vaccination?	☐	☐
• Have you ever had any bad reaction or side effect from any vaccination?	☐	☐
• Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder or who is on chemotherapy for cancer?	☐	☐
• Do you have a family history of immunodeficiency?	☐	☐
• Have you received any injection of immune globulin or any blood product during the past 12 months?	☐	☐

**** DO NOT COMPLETE GRAY AREAS. FOR PHYSICIAN ONLY***

Vaccine Information Sheets	Edition Date	Given to Patient
Tetanus/Diphtheria		☐ Yes ☐ No
Measles, Mumps, Rubella		☐ Yes ☐ No
Hepatitis B		☐ Yes ☐ No
Polio		☐ Yes ☐ No
Varicella		☐ Yes ☐ No
Meningococcal		☐ Yes ☐ No
Yellow Fever		☐ Yes ☐ No
Hepatitis A		☐ Yes ☐ No
Influenza		☐ Yes ☐ No
Pneumococcal		☐ Yes ☐ No
Typhim		☐ Yes ☐ No
Oral Typhoid		☐ Yes ☐ No
Japanese Encephalitis		☐ Yes ☐ No
Rabies		☐ Yes ☐ No

Form 4292-NS (Rev. 01/09) ©2013 Thomas Jefferson University Hospitals. All rights reserved.

Pre-Travel Needs Assessment

Consent for Vaccination

I, ____ have been provided with and have read the CDC vaccine information sheet(s) and have had the opportunity to ask questions about the benefits and risks of

____ Vaccination(s).

I understand that there is a possibility that I will experience an adverse side effect from the vaccine.

I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the vaccine is not known on the developing fetus.

X ____ ______________________
Signature Date

Vital Signs

T	P	R	BP

Immunizations/Vaccinations	Date	Lot	Site	Date	Lot	Site	Date	Lot	Site
Hepatitis A			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Hepatitis B			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Hepatitis A/ Hepatitis B combined			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Influenza			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Japanese encephalitis			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Measles, Mumps, Rubella			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Meningococcal meningitis			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Pneumococcal (conjugate or polysaccaride)			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Poliomyelitis, primary series			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Polio booster			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Rabies (vaccine or IG)			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Tetanus, Diphtheria (Td) if > 7 years of age			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Typhoid fever (oral/IM)			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Varicella (chicken pox)			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Yellow fever			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Other:			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Other:			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid
Other:			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid			☐ L ☐ R Deltoid

☐ **Observed for ____________ minutes – No adverse reaction noted.**

 ©2013 Thomas Jefferson University Hospitals. All rights reserved.

Pre-Travel Needs Assessment

Prescriptions Given:

Notes

X

Signature MD (or) CRNP

Travel Medicine Information Sheets Given: (contents of folder)

☐ Vaccine Information ☐ Malaria ☐ General Information Sheet ☐ Travel medicine kit ☐ Country/Region of travel

☐ Travel Health Insurance ☐ Rabies Info ☐ Sources of Deet/Picaridin ☐ Food/water precautions ☐ Travel Diarrhea

☐ Other ______________________ ☐ Other ______________________

 ©2013 Thomas Jefferson University Hospitals. All rights reserved.