MORLEDGE
MEDICAL
Internal & Travel Medicine

Pre-Travel Consultation Questionnaire

*Last Name:*_____ *First Name:*_____ *Middle:*_____

Address: _____ *Apt.*_____

*City:*_____ *State:*____ *Zip:*_____ *DOB:*_____ *Age:*_____ *Gender: M*____ *F*____

*Home Phone:*_____ *Work:* _____ *Cell:* _____ *Email Address :*_____

*Employer:*_____ *Occupation:*_____

*Emergency Contact:*_____

Name: _____ *Relationship:* _____ *Phone:*_____

Referred by: ☐ *Physician* ☐ *Friend/Family* ☐ *Health Dept.* ☐ *Other*_____

Primary Care Physician: _____ *Phone:*_____

May we send your primary care physician a copy of your immunization record? ☐Yes ☐No

May we contact you regarding boosters, medical research or health information regarding your trip? ☐Yes ☐No

Please list the countries you are traveling to in order. **Approximate length of stay in each country.**

_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

Departure Date: ___/___/___ *Return Date:* ___/___/___ *Reason for travel:* ☐**Tourist** ☐**Business** ☐**Student** ☐**Other**_____

Accommodations during travel: ☐**Hotel** ☐**Private Home** ☐**Cruise** ☐**Camping** ☐**Other** _____

Do you plan to visit only tourist areas or major cities ?..... ☐Yes (Length of stay)_____ ☐No

Do you plan to visit rural areas?..... ☐Yes (Length of stay)_____ ☐No

Do you plan to visit rural areas during evening or nighttime hours?..... ☐Yes (Length of stay)_____ ☐No

Do you plan to go hiking or backpacking?..... ☐Yes..... ☐No

Do you plan to go bicycling?..... ☐Yes..... ☐No

Do you plan to go swimming?..... ☐Yes..... ☐No

If yes, ☐Chlorinated Pool ☐Fresh Water Lake or Stream ☐Ocean

Do you plan to travel or to climb to high altitudes?..... ☐Yes..... ☐No

Do you plan to scuba dive?..... ☐Yes..... ☐No

If yes. Are you certified?..... ☐Yes..... ☐No

When is air travel scheduled after last dive? _____

Louis J. Morledge, MD, pLLC
150 East 58 Street, 18th Floor, New York, NY 10155 • Phone: 212-583-2830 • Fax: 212-583-0444 • www.morledgemedical.com

Please check yes or no-

Do you have heart problems? ☐Yes ☐No
Do you have a cardiac arrhythmia or irregularity? ☐Yes ☐No

Are you allergic to bee stings? ☐Yes ☐No

Do you have high blood pressure or take high blood pressure medicine? ☐Yes ☐No

Are you allergic to eggs, yeast, or any other foods? ☐Yes ☐No

Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy? ☐Yes ☐No

Do you have lung disease, asthma, chronic bronchitis, or shortness of breath? ☐Yes ☐No

Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS, or any other immune system problem? ☐Yes ☐No

Do you have a stomach or bowel condition, such as bowel irritability, frequent diarrhea or constipation? ☐Yes ☐No

Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today? ☐Yes ☐No

Do you have any skin condition such as psoriasis, eczema or shingles? ☐Yes ☐No

Have you ever fainted from an injection or from having your blood drawn? ☐Yes ☐No

Do you experience nightmares or insomnia? ☐Yes ☐No

Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination? ☐Yes ☐No
If yes, please describe: _____

_____

Do you have a history of depression or psychiatric disorders? ☐Yes ☐No

During the past three (3) months have you received a transfusion of blood or plasma, or been given medicine called immune globulin or Rho-gam? ☐Yes ☐No

Do you have Diabetes? ☐Yes ☐No
If yes, do you take insulin? ☐Yes ☐No

Have you received any vaccinations in the past 4 weeks? ☐Yes ☐No
If yes, please specify_____

Do you have tuberculosis? Have you ever tested positive for tuberculosis? ☐Yes ☐No

Are you prone to motion sickness? ☐Yes ☐No

Do you have an active nerve condition? ☐Yes ☐No
Do you have a history of Guillain-Barre Syndrome or seizures? ☐Yes ☐No

Have you ever had headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet? ☐Yes ☐No

Are you allergic to any drug, medication, vaccine, or vaccine component, such as penicillin, thimerosol, formalin, sorbitol,albumin, animal serum? ☐Yes ☐No
If yes, what are you allergic to?

_____

_____

_____

Are you currently taking any medications including oral contraceptives and blood pressure medication? ☐Yes ☐No
If yes, please list:

_____

_____

_____

_____

Other Medical Conditions:

History of tendon rupture? ☐Yes ☐No

Sickle cell anemia/trait? ☐Yes ☐No

Splenectomy? ☐Yes ☐No

Previous Immunizations:

	Date
Hepatitis A	
Hepatitis B	
Typhoid	
Influenza	
Yellow Fever	
Polio	
Pneumonia	
Meningitis	
Tetanus/Diphtheria	
Measles, Mumps, Rubella	
Chicken Pox	
Japanese Encephalitis	
Rabies	
Other	

Have you ever taken malaria pills? ☐Yes ☐No
If yes, did you have any side-effects? ☐Yes ☐No
If yes, please explain: _____

_____

Questions For Women

Are you pregnant? ☐Yes ☐No

Are you breastfeeding (nursing) now? ☐Yes ☐No

Do you plan to become pregnant within the next three months? ☐Yes ☐No

Do you have problems with vaginitis? ☐Yes ☐No

The above information is accurate to my best recollection.

_____
Patient Initial and Date here.

Health Professional: _____
Initial and Date here.

Louis J. Morledge, MD, pLLC
150 East 58 Street, 18th Floor, New York, NY 10155 · Phone: 212-583-2830 · Fax: 212-583-0444 · www.morledgemedical.com