Division of
Infectious Diseases

Columbia University
Medical Center

Pre-Travel Questionnaire

Prior to your appointment, please complete and submit this form to:

Travel Medicine- Columbia University Infectious Disease Associates

Fax: 212-305-1754

Email: infectious_diseases@columbia.edu

Standard Mail: Infectious Disease Associates
161 Fort Washington Avenue
IP 2-215
New York, New York 10032

Name: Last ____________________ First ______________ **DOB: ___ / ___ / ______**

1a. What are your departure and return dates?

Departure: ___ / ___ / ______

Return: ___ / ___ / ______

1b. Where and when will you be traveling?

Country	Date In	Date Out
1. _____________	___ / ___ / ______	___ / ___ / ______
2. _____________	___ / ___ / ______	___ / ___ / ______
3. _____________	___ / ___ / ______	___ / ___ / ______
4. _____________	___ / ___ / ______	___ / ___ / ______

2a. Are you allergic to any of these medications?

	No	Yes	Don't know
Tetracycline or Doxycycline	[ ]	[ ]	[ ]
Chloroquine / Mefloquine	[ ]	[ ]	[ ]
Malarone (atovaquone/proguanil)	[ ]	[ ]	[ ]
Ciprofloxacin	[ ]	[ ]	[ ]

2b. In the space below, please write down any medications to which you are allergic:

2c. In the space below, please write down any medications which you are currently taking:

3. Have you ever received any of these vaccines/immunizations?

	No	Yes	If yes, what year?
Typhoid vaccine		[ ]	[ ] ______________
Yellow fever vaccine	[ ]	[ ]	______________
Hepatitis A vaccine	[ ]	[ ]	______________
Hepatitis B vaccine	[ ]	[ ]	______________
Meningococcal vaccine	[ ]	[ ]	______________
Japanese encephalitis vaccine	[ ]	[ ]	______________
Rabies vaccine	[ ]	[ ]	______________
Cholera vaccine	[ ]	[ ]	______________

4. Have you ever received a booster to any of these vaccines/immunizations?

	No	Yes	If yes, what year was the last booster?
Polio booster	[ ]	[ ]	______________
Tetanus booster		[ ]	[ ] ______________
Pertussis booster		[ ]	[ ] ______________