Capital Area Pediatrics

Pre-Travel Questionnaire

Please complete a separate form for each family member. Please bring a vaccine record for anyone that is not already a Capital Area Pediatrics patient.

Full Name: _____ Date of Birth: _____ Age: _____

Travel Details

Destination (Country and Region/ City): _____

Travel Dates: From _____ To _____ (Duration: _____ days)

Environment (check all that apply):

☐ Urban ☐ Rural ☐ Hiking ☐ Camping ☐ Backpacking ☐ Contact with Animals ☐ Cruising
☐ High Altitude Travel (>8,000 ft)

Known allergies (medication, food, environmental): _____

Previous severe reaction to any vaccine: ☐ Yes ☐ No

If yes, please describe: _____

Medical History (for NEW Capital Area Pediatrics patients only):

Medications: _____

Last Typhoid vaccine date: _____ Typhoid Oral or Injectable: _____

Please check all that apply:

☐ Asthma (severe) ☐ Breastfeeding ☐ Cancer ☐ Chronic lung disease ☐ Diabetes ☐ DiGeorge syndrome ☐ Heart condition (incl. arrhythmia) ☐ Hypertension ☐ Immunodeficiency disorder (e.g., HIV, autoimmune) ☐ Immunosuppressive meds (e.g., steroids, chemo) ☐ Myasthenia gravis ☐ Neurological disorder ☐ Pregnancy ☐ Psychiatric illness ☐ Seizure disorder ☐ Thymus disease / Thymoma

Details of checked conditions above:

_____

_____

I certify that the above information is correct:

Name: _____ Signature: _____ Date: _____

If patient is a minor, patient's name: _____ Relationship: _____