

University of Utah Medical Center
INTERNATIONAL TRAVEL CLINIC – MISSIONARY SCREENING FORM

Name: _____ DOB: _____ Age: _____
 Country of Birth: _____ Date of Immigration to U.S.: _____

TRAVEL INFORMATION

Date entering MTC: _____ MTC Location: _____ Length of Mission: 1 ½ yrs 2 yrs 3 yrs
 Country of Mission: _____ Name of Mission: _____

PERSONAL MEDICAL INFORMATION

- Yes No Did you receive your childhood vaccines?
 Yes No Have you ever had chicken pox disease or vaccine series?
 Yes No Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?
 Yes No Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last three months?
 Yes No Do you have any seizure or brain problems?
 Yes No Have you received gamma-globulin or blood transfusions with the past year?
 Yes No Have you received a TB test in the past four weeks?
 Yes No Have you ever taken anti-malarial medication? If yes, what medication: _____
 Did you tolerate it well? Yes No
 Yes No Are you at-risk for blood borne infections such as: HIV, AIDS, or Hepatitis B? (Risks include: blood transfusions, unprotected homosexual or heterosexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.)
 Yes No (*Females*) Is there any chance that you could be pregnant?

Allergies:

Are you allergic to any of the following?

- Sulfa Erythromycin Neomycin Streptomycin Polymyxin B
 Eggs Chickens Baker's Yeast Gelatin Bee Stings
 Other Please list: _____

Check if you have/had any of the following diseases or medical problems: None

- Hepatitis/Liver Disorders Myesthenia gravis Prostate problems Diabetes
 Thrombophlebitis/blood clot Seizures/Epilepsy Kidney Disease Heart Disease/Attacks
 Recurrent pneumonia Mental/emotional diseases Irregular heart rhythms HIV/AIDS
 Splenectomy Thymus disease/Thymectomy Blood thinning meds
 Psoriasis Hearing problems Retinal or Visual Field Changes
 Conditions treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis)
 Other: _____

MEDICATION INFORMATION

(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking

Medication	Reason for Taking

IMMUNIZATION INFORMATION

Vaccine	Date of last immunization	For Office Use		Vaccine	Date of last immunization	For Office Use	
			D/D				D/D
Chickenpox (Varicella)				Pneumococcal			
Hepatitis A (0, 6 M)				Polio/IPV/OPV			
Hepatitis B (0, 1, 6 M)				Rabies (Pre-Ex 0, 7, 14-28 d) (Post-Ex 2 add doses req)			
Hepatitis A & B (Twinrix) (0, 1, 6 M) (0, 7, 21 d, 12 M)				Tetanus/Diphtheria			
Influenza				Tetanus/Diphtheria/Pertussis			
Gamma Globulin				Typhoid oral (0, 2, 4, 6 d)			
Japanese Encephalitis (0, 7, 30 d) (0, 7, 14 d)				Typhoid injectable			
Meningococcal (Menactra)				Yellow Fever			
Meningococcal (Menomune)				Zostavax			
MMR (0, 1 M) (Measles/Mumps/Rubella)							

FOR OFFICE USE

V1 = Visit Date: _____ C = Completed series **D/D = Discussed/Declined**
 V2 = Visit Date: _____ L# = Lot Number 1 = Not covered by insurance 5 = Get from PCP
 V3 = Visit Date: _____ Hx = History of disease 2 = Pt feels don't need it 6 = Not enough time before travel
3 = Personal beliefs 7 = Will get at MTC
 Prescriptions given: Yes No M = Month
d = days

WRITTEN EDUCATION

TRAVAX report for countries visiting UofU International Travel Clinic Book _____
 CultureGram for countries visiting VIS's for vaccine given _____

VERBAL EDUCATION

Immunizations Jet lag Fresh water/Leptospirosis
 Food & water safety Motion sickness Theft
 Traveler's diarrhea Sun protection Health Issues
 Insect precautions Animal bites Illness back home

REGION SPECIFIC / OTHER EDUCATION

Yellow Fever Altitude sickness Avian Flu Schistosomiasis Ticks
 Japanese Encephalitis Scuba diving Chikungunya Trypanosomiasis
 Malaria Ocean/beach Dengue TB

NOTES

Nurse: _____

Date: _____

Reviewed By: _____

Date: _____