



Omega Medical Center
Your Occupational Health Resource
 D.O.H.R., L.L.C.

TRAVELERS QUESTIONNAIRE

Please complete and fax to (302) 266-6369.

Name _____ Date of Birth _____
 Please print Company _____
 Work Ph# _____

Dates Traveling _____
 Countries (in order of travel) _____
 Drug allergies _____
 Medical conditions _____
 Prescription and non-prescription medications currently taking _____

Immunization Record

Tetanus / Diptheria	Yes ___ No ___	Date Received _____
Flu Vaccine	Yes ___ No ___	Date Received _____
Hepatitis B	Yes ___ No ___	Date Received 1 _____
		2 _____
		3 _____
Hepatitis A	Yes ___ No ___	Date Received 1 _____
		2 _____
Meningococcal	Yes ___ No ___	Date Received _____
MMR	Yes ___ No ___	
MMR Booster	Yes ___ No ___	
Polio	Yes ___ No ___	
Polio Booster	Yes ___ No ___	
Typhoid Oral	Yes ___ No ___	Date Received _____
Typhoid Injection	Yes ___ No ___	Date Received _____
Yellow Fever	Yes ___ No ___	Date Received _____

For valuable travel information visit: www.cdc.gov/travel

Comments: _____