

1. General Information		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	*Today's Date (Clinic Visit Date) (Month/Day/Year):			
*Country of Birth:			Primary Country of Residence Before Age 10:				
Country of Citizenship:			*Country of Current Residence:				
<input type="checkbox"/> Migrant → If checked, <input type="checkbox"/> Migration Travel ONLY? (If checked, use Migrant Form instead)			If you were not born in (COUNTRY), indicate as closely as possible the date you first arrived here (Month/Day/Year):				
2. History of Recent Travel		List in order, starting with the most recent trip, all international travel in the past 12 months. Enter separate records for each country visited during the trip if dates for each country are known. Indicate if the trip included travel on a Ship.					
*Trip Start Date Month/Day/Year	*Trip End Date Month/Day/Year	*Country	Ship	*Trip Start Date Month/Day/Year	*Trip End Date Month/Day/Year	*Country	Ship
1.			<input type="checkbox"/>	4.			<input type="checkbox"/>
2.			<input type="checkbox"/>	5.			<input type="checkbox"/>
3.			<input type="checkbox"/>	6.			<input type="checkbox"/>
3. History of Previous Travel		List all countries visited or resided in during the past 5 years or earlier if relevant (exclude those in past 12 months listed above). List each country only once. CIRCLE all years of travel to that country.					
*Country:	1.	2.	3.	4.			
*Years (20-)	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+		
*Country:	5.	6.	7.	8.			
*Years (20-)	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+	17 16 15 14 13 12+		
DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY CLINICIAN – DO NOT WRITE BELOW THIS LINE							
4. Exposure Details							
*Country of Exposure/Other (Enter the country of exposure or check the applicable box)							
Country of Exposure: _____ <input type="checkbox"/> Exposure Country Not Ascertainable <input type="checkbox"/> Ship <input type="checkbox"/> Plane							
More Specific Place of Exposure: (below country level – state, city, place, event) _____							
If Country of Exposure is 'Not Ascertainable', 'Ship', or 'Plane', enter Region of Exposure: _____ <input type="checkbox"/> Exposure Region Not Ascertainable							
*Reason for Travel Related to Current Illness: (Check One) <input type="checkbox"/> Tourism <input type="checkbox"/> Business/Corporate/Conference <input type="checkbox"/> Research <input type="checkbox"/> Education/Student <input type="checkbox"/> Migration <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Planned Medical Care <input type="checkbox"/> Military <input type="checkbox"/> Visiting Friends or Relatives <input type="checkbox"/> Missionary/Humanitarian/Volunteer/Community Service If VFR, specify: <input type="checkbox"/> Individual is immigrant (residing in high-income country) from the region to which s/he is traveling (low-income country) <input type="checkbox"/> Individual is the child/descendant of an immigrant (residing in high-income country) from the region to which s/he is traveling (low-income country) <input type="checkbox"/> Individual is the spouse or partner of an immigrant (residing in high-income country) from the region to which s/he is traveling (low-income country)							
*Mark if Expatriate (Check if applicable): <input type="checkbox"/> Expatriate				*Clinical Setting (Check One): <input type="checkbox"/> Seen During Travel <input type="checkbox"/> Seen After Travel			
*Patient Type (Check One): <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> TeleConsult-Outpatient <input type="checkbox"/> TeleConsult-Inpatient							
*Highest level of care required for this illness? (Check One): <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient ward <input type="checkbox"/> Inpatient ICU							
If hospitalized, indicate if this was During Travel and/or After Return: <input type="checkbox"/> During Travel <input type="checkbox"/> After Return							
*Did the patient receive pre-travel information? (Check One): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know							
If YES, select the MAIN SOURCE of information: <input type="checkbox"/> Internet <input type="checkbox"/> Travel medicine specialist <input type="checkbox"/> General Practitioner <input type="checkbox"/> Relative/friend <input type="checkbox"/> Travel Agency <input type="checkbox"/> Other _____							
*Main Presenting Symptoms or Reason for Referral (Check at least one symptom or reason below, but include all that apply):							
Gastrointestinal <input type="checkbox"/> Abdominal pain/discomfort <input type="checkbox"/> Acute diarrhea <input type="checkbox"/> Bloating <input type="checkbox"/> Bloody diarrhea (dysentery) <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Passed worm <input type="checkbox"/> Vomiting <input type="checkbox"/> Weight loss <input type="checkbox"/> Other							
Genitourinary <input type="checkbox"/> Discharge <input type="checkbox"/> Dysuria/frequency <input type="checkbox"/> Flank pain <input type="checkbox"/> Genital Lesion <input type="checkbox"/> Hematuria <input type="checkbox"/> Other							
Musculoskeletal <input type="checkbox"/> Arthralgia <input type="checkbox"/> Arthritis <input type="checkbox"/> Myalgia <input type="checkbox"/> Focal musculoskeletal pain <input type="checkbox"/> Other							
Neurologic <input type="checkbox"/> Confusion <input type="checkbox"/> Dizziness <input type="checkbox"/> Focal symptoms <input type="checkbox"/> Headache <input type="checkbox"/> LOC/Syncope <input type="checkbox"/> Neck stiffness/photophobia <input type="checkbox"/> Seizure <input type="checkbox"/> Other							
Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Pleuritic chest pain <input type="checkbox"/> SOB <input type="checkbox"/> URI symptoms (runny nose/sore throat) <input type="checkbox"/> Wheeze <input type="checkbox"/> Other							
Skin <input type="checkbox"/> Diffuse rash <input type="checkbox"/> Focal rash <input type="checkbox"/> Itch <input type="checkbox"/> Skin lesion or nodule <input type="checkbox"/> Skin infection (superficial or deep) <input type="checkbox"/> Bite/scratch/sting <input type="checkbox"/> Other							
HEENT <input type="checkbox"/> Ear symptoms <input type="checkbox"/> Eye symptoms <input type="checkbox"/> Nasal symptoms <input type="checkbox"/> Throat symptoms <input type="checkbox"/> Mouth or Dental symptoms <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Other							
Abnormal Lab Test <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Positive serology <input type="checkbox"/> Other abnormal blood test <input type="checkbox"/> Abnormal radiologic finding <input type="checkbox"/> Positive stool examination <input type="checkbox"/> Positive stool test <input type="checkbox"/> Other							
<input type="checkbox"/> Cardiac		<input type="checkbox"/> Fatigue		<input type="checkbox"/> Fever/Sweats/Chills		<input type="checkbox"/> Lymphatic	
<input type="checkbox"/> Psychologic		<input type="checkbox"/> Thrombosis		<input type="checkbox"/> Trauma/Injury		<input type="checkbox"/> Screening	
<input type="checkbox"/> Other If 'Other', Specify:							
*Date of Illness Onset (Use 1 of the 3 options)							
(1) _____ (MM/DD/YYYY)							
(2) Number (1-30) _____ of (circle one) days / weeks / months / years before presentation							
(3) <input type="checkbox"/> Unknown/Not Applicable							
*Activities During Travel (Check all that apply)							
<input type="checkbox"/> None/Not Applicable <input type="checkbox"/> Provided medical care <input type="checkbox"/> Staying/eating in local homes <input type="checkbox"/> Trekking <input type="checkbox"/> Attended mass gathering <input type="checkbox"/> Blood/body fluid exposure <input type="checkbox"/> Antibiotic taken during travel <input type="checkbox"/> Unplanned medical or dental care <input type="checkbox"/> Animal exposure <input type="checkbox"/> Freshwater exposure							

* = These items are required fields for successful online data entry. Note: Sections 2 & 3 may be omitted if not applicable.

5. *Pre-Existing Conditions – those present prior to onset of the current travel-related illness: (check all that apply)

None Known to Exist

Pregnancy (any trimester) Insulin-dependent Diabetes Mellitus

HIV Infection → If checked, select stage: Stage 1 Stage 2 Stage 3 Stage Unknown
 Patient on antiretroviral therapy? Yes No Unknown

Malignancy under active chemo- or radio-therapy (within 3 months) or advanced incurable malignancy → Solid malignancy Hematological malignancy

Transplant at any time → If checked, select type: Bone marrow transplant Solid organ transplant

Immunosuppressing/Immunomodulating Agents (currently or within 3 months)

Other Immunocompromising Condition Specify: _____

6. *Diagnoses ***Is the main diagnosis causing today's visit travel related? (Check One)**

Travel Related Not Ascertainable Not Travel Related Imported Infection acquired in home country prior to travel

1) <input type="checkbox"/> *Primary	*Final Diagnosis: _____	Other info (species, organism, etc.): _____	
	*Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	*Activity: <input type="checkbox"/> Active <input type="checkbox"/> Resolved	<input type="checkbox"/> Ascertained by Screening
	*Diagnosis Method (Check all that apply)		
	<input type="checkbox"/> Microscopy	<input type="checkbox"/> Paired antibody (serology): seroconversion/≥4-fold rise in titre	<input type="checkbox"/> Radiology <input type="checkbox"/> Clinical
	<input type="checkbox"/> Culture	<input type="checkbox"/> Single positive Antibody (serology) result	<input type="checkbox"/> Histopathology
	<input type="checkbox"/> Antigen test	<input type="checkbox"/> Laboratory macroscopic identification	<input type="checkbox"/> Typical exposure history
	<input type="checkbox"/> Nucleic acid amplification test (e.g. PCR, LAMP, RT-PCR)	<input type="checkbox"/> Other Specify: _____	
2) <input type="checkbox"/> *Primary	*Final Diagnosis: _____	Other info (species, organism, etc.): _____	
	*Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	*Activity: <input type="checkbox"/> Active <input type="checkbox"/> Resolved	<input type="checkbox"/> Ascertained by Screening
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	<input type="checkbox"/> Antigen test	<input type="checkbox"/> Laboratory macroscopic identification	<input type="checkbox"/> Typical exposure history
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3) <input type="checkbox"/> *Primary	*Final Diagnosis: _____	Other info (species, organism, etc.): _____	
	*Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	*Activity: <input type="checkbox"/> Active <input type="checkbox"/> Resolved	<input type="checkbox"/> Ascertained by Screening
	*Diagnosis Method (Check all that apply)		
	<input type="checkbox"/> Microscopy	<input type="checkbox"/> Paired antibody (serology): seroconversion/≥4-fold rise in titre	<input type="checkbox"/> Radiology <input type="checkbox"/> Clinical
	<input type="checkbox"/> Culture	<input type="checkbox"/> Single positive Antibody (serology) result	<input type="checkbox"/> Histopathology
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4) <input type="checkbox"/> *Primary	*Final Diagnosis: _____	Other info (species, organism, etc.): _____	
	*Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	*Activity: <input type="checkbox"/> Active <input type="checkbox"/> Resolved	<input type="checkbox"/> Ascertained by Screening
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	<input type="checkbox"/> Culture	<input type="checkbox"/> Single positive Antibody (serology) result	<input type="checkbox"/> Histopathology
	<input type="checkbox"/> Antigen test	<input type="checkbox"/> Laboratory macroscopic identification	<input type="checkbox"/> Typical exposure history
	<input type="checkbox"/> Nucleic acid amplification test (e.g. PCR, LAMP, RT-PCR)	<input type="checkbox"/> Other Specify: _____	

We are interested in collecting antibiotic resistance information on a limited number of bacteria only. If there is a CULTURE diagnosis of any of the nine following bacteria, then complete the antibiotic resistance information on next page:

Salmonella species (#192)	Salmonella typhi (#193)	Salmonella paratyphi (#632)	Campylobacter (#115)	Shigella species (#200)
Staphylococcus aureus	E. coli	Klebsiella pneumoniae	Streptococcus pneumoniae	

***Antibiotic Resistance** Enter antibiotic sensitivity/resistance information only if the diagnosis method is CULTURE
 Enter antibiotic sensitivity information for the one organism considered most clinically important
 S=Sensitive, I/R=Intermediate/Resistant, Unk=Unknown/Not Done/Not Reported (Check 'I/R' if results include I-Intermediate or R-Resistant for any drug in the category)
 Sensitivity Testing Not Done

192 – SALMONELLA SPECIES or (if organism is Salmonella species) 108 – BACTEREMIA, 699 – SEPSIS, 739 – ABSCESS, PYOGENIC LIVER, 259 – ABSCESS, PYOGENIC (NOT SKIN, NOT TONSILLAR, NOT LIVER, NOT LUNG) Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Other <input type="checkbox"/> Unknown	193 – SALMONELLA TYPHI or 632 – SALMONELLA PARATYPHI 108 – BACTEREMIA, 699 – SEPSIS, 739 – ABSCESS, PYOGENIC LIVER, 259 – ABSCESS, PYOGENIC (NOT SKIN, NOT TONSILLAR, NOT LIVER, NOT LUNG) Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood/Bone Marrow <input type="checkbox"/> Other <input type="checkbox"/> Unknown																																																												
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Here we are interested in resistance for STAPHYLOCOCCUS AUREUS and have listed the codes for which Staphylococcus aureus culture is most likely (Note: Do NOT enter information for other Staph species e.g. Staph epidermidis/coagulase negative staphylococcus) 413 – SKIN AND SOFT TISSUE INFECTION (SKIN ABCESS or SECONDARY BACTERIAL INFECTION OF EXISTING LESION), 537 – ENDOCARDITIS, 785 – SKIN AND SOFT TISSUE INFECTION, SUPERFICIAL: IMPETIGO, FOLLICULITIS, FURUNCLE, CARBUNCLE, PARONYCHIA, ECTHYMA, 108 – BACTEREMIA, 699 – SEPSIS, 739 – ABSCESS, PYOGENIC LIVER, 259 – ABSCESS, PYOGENIC (NOT SKIN, NOT TONSILLAR, NOT LIVER, NOT LUNG) , 144 – PNEUMONIA (BACTERIAL OR VIRAL), OTHER SPECIFIC ETIOLOGY, 142 – SKIN AND SOFT TISSUE INFECTION: ERYSIPELAS, CELLULITIS, GANGRENE Specimen Type: <input type="checkbox"/> Swab <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Other <input type="checkbox"/> Unknown																																																													
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