

Patient
Name _____

Travel Health History

Please be sure to answer all questions below as completely and accurately as possible and include copies of all available immunization records. This information will be used in planning for your travel health recommendations, which will be prepared as soon as the information is received. *An incomplete questionnaire may delay your recommendations and immunizations.* All information is strictly confidential. Please print clearly. Attach additional sheets if necessary.

Name _____ Age _____ Sex M F
Address _____
City _____ State (country) _____ Zip _____
Home Phone _____ Business phone _____ Cell Phone _____
Date of Birth _____ Place of Birth _____
Weight (approximate) _____ lbs. Social Security # _____

Have you ever been a patient at our Travel Immunization Center before?
No Yes If yes, when? _____

Business travelers: Please indicate company or organization: _____

1. Planned Itinerary---in EXACT ORDER of Travel:

Departure Date: _____ Return Date (approximate) _____

<u>Country</u> (list cities)	<u>Length of Stay</u>	<u>Any Rural Travel</u> (circle)	
1. _____	_____	No	Yes
2. _____	_____	No	Yes
3. _____	_____	No	Yes
4. _____	_____	No	Yes
5. _____	_____	No	Yes
6. _____	_____	No	Yes
7. _____	_____	No	Yes
8. _____	_____	No	Yes

Attach printed/detailed itineraries (e.g. from cruise line, travel agent, etc.) If available

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2. Accommodations: (Check all that apply)

Resort Cruise Ship Private Home Camp
 Dormitory Major Hotel Small Hotel
 Youth Hostel Other _____

3. Purpose of Travel: (Check all that apply)

Business Teaching Biking/Hiking
 Volunteer Organization Vacation Diving
 Safari Foreign Study Climbing
 Missionary Other _____

4. Medical History:

Do you have *any allergies*? (drugs, foods,--especially eggs?) No Yes

If yes, please describe allergy and reaction _____

Have you ever had any of the following? (Circle yes or no. If yes, give details and dates)

Fever in the past 48 hours	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Kidney Disease	No	Yes	_____
Stomach Diseases (ulcer, etc.)	No	Yes	_____
Respiratory Disease (asthma, etc.)	No	Yes	_____
Neurological Disorder	No	Yes	_____
Seizure Disorder? Epilepsy	No	Yes	_____
Depression	No	Yes	_____
Psychiatric Disorder	No	Yes	_____
HIV or Immune Deficiency	No	Yes	_____
Cancer or Leukemia	No	Yes	_____
Hives	No	Yes	_____
Psoriasis (diagnosed by a physician)	No	Yes	_____
Myasthenia gravis, DiGeorge Syndrome or thymoma/thymus Surgery	No	Yes	_____

5. Current Medications: Are you taking any medications? No Yes

List all current medications and dosage schedules (including oral
contraceptives and over the counter drugs): _____

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6. Immune SystemHave you ever received any of the following treatments?**

<u>Treatment</u>			<u>Reason</u>	<u>Dates</u>
Radiation Therapy	No	Yes	_____	_____
Cancer Chemotherapy	No	Yes	_____	_____

Have you taken Cortisone/Steroids or other medications that affect the immune system? No Yes

Indicate the reason and the dosages, forms (pills, injection, inhaler, etc.), dates and duration of treatment.

Do you live with (or work closely with) anyone who had AIDS, an AIDS-like condition, a suppressed immune system, or who is receiving any of the treatments/medications listed above? No Yes

**The purpose of these questions is to assist us in assessing any possible risk to you or your contacts from certain immunizations.

7. Prior Immunizations: Indicate the month/year of all doses received. Please respond for each and attach copies of all available immunization records.

_____ Tetanus	_____ Gamma Globulin
_____ Diptheria	_____ Hepatitis A Vaccine
_____ Measles	_____ Hepatitis B Vaccine
_____ Mumps	_____ Typhoid—Injected
_____ Rubella	_____ Typhoid—Oral
_____ Polio (series & booster)	_____ Yellow Fever
_____ Influenza (flu shot)	_____ Cholera
_____ Pneumococcal (Pneumonia)	_____ Rabies
_____ Meningococcal (Meningitis)	_____ Japanese Encephalitis
_____ Varicella (Chicken Pox)	_____ Other

Have you ever had an adverse reaction to any immunizations? No Yes
If yes, specify immunization and reaction: _____

8. WOMEN ONLY:

Are you pregnant now or do you suspect that you might be pregnant? _____

Are you planning a pregnancy in the next six months? _____

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When was your last menstrual period? Date: _____

9. PHYSICIAN INFORMATION: Who is your personal physician?

Name _____

Address _____ City _____

State _____ Zip _____ Phone _____

10. ADDITIONAL INFORMATION:

Please include any additional information that you think might assist us in preparing your travel health recommendations: _____

Please check to make sure that you have answered **ALL** questions.

Incomplete forms may delay processing.

Please sign below and return the completed form to initiate the preparation of your travel health recommendations and immunizations (**unsigned forms cannot be processed**).

Signature

Date

The information provided in this questionnaire is not a substitute for medical advice from a health care provider on an individual basis.

Travel-related vaccines and medications are generally not covered by health insurance. The patient is responsible for payment in full at the time of service.