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| **TRAVELER HISTORY FORM**  Complete this form and bring it to the clinic appointment along with all immunization records. | | |
| Name: DOB: □ Male □ Female  Home Phone: Work Phone: Mobile Phone:  Home Address:  City: State: Zip:  Email:  Primary care physician: Phone:  Patient ID#: Primary insurance:  Does your insurance cover:  Health care overseas? □ Yes □ No □ Not sure  Medical evacuation? □ Yes □ No □ Not sure  Birth country: | | |
| **TRAVEL PLANS** (list additional information on back of form if needed): | | |
| **Purpose of trip** (check all that apply)  □ Vacation □ Education/research □ Adoption □ Visit friends or family □ Missionary/volunteer/humanitarian relief  □ Work (urban, office-based, or conference) □ Work (rural, outdoors, or in local community) □ To obtain medical or dental care □ Other  **Planned activities**(list all):  **Will you be*:***  Visiting areas that are:   * Rural □ Yes □ No □ Not sure * Urban □ Yes □ No □ Not sure * Primitive or remote □ Yes □ No □ Not sure   Ascending to high altitudes (8,000 ft or higher)? □ Yes □ No □ Not sure  Working with potential exposure to body fluids (e.g., medical or dental work)? □ Yes □ No □ Not sure  Working with exposure to animals? □ Yes □ No □ Not sure  Potentially having new sexual partners? □ Yes □ No □ Not sure  **Accommodations** (check all that apply):  □ Resort/large hotel □ Small hotel/guest house/B&B □ Cruise ship □ Private home (with locals) □ Private home (with relatives)  □ Private home (expatriate or high-end) □ Primitive camping □ Up-scale camp/lodge □ Dormitory/ hostel  □ Other  **Previous international travel** **(year/destination):** | | |
| **Countries and cities in order of visit** | **Arrival Date** | **Departure Date** |
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| **Name** | | **DOB** | **Date** |
| **HEALTH HISTORY (Check all that apply)** | | | |
| **Allergies**  □ Antibiotics (e.g., penicillin, sulfa)  □ Other medications  □ Egg  □ Latex  □ Gelatin  □ Yeast  □ Bees/wasps  □ Seasonal  □ Other  □ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset):  **Cancers/blood disorder**  □ Coagulation disorder  □ History of cancer or blood disorder  □ Other  **Cardiovascular**  □ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)  □ Implanted pacemaker or automatic defibrillator  □ Heart attack  □ High cholesterol  □ High blood pressure  □ Stroke  □ Other  **Endocrine**  □ Diabetes  □ Thyroid disease  □ Other  **GI**  □ Crohn’s disease or ulcerative colitis  □ IBS  □ GERD  □ Chronic hepatitis  □ Cirrhosis or liver failure  □ Other | **Immune system**  □ Steroids by mouth within last 3 months  □ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)  □ Spleen removed  □ Thymus disease or thymectomy  □ HIV/AIDS   * Most recent CD4: * Most recent viral load:   □ Organ, bone marrow, stem cell transplant  □ Other  **Kidneys**  □ Dialysis  □ Kidney insufficiency  □ Other  **Lungs**  □ Asthma  □ Emphysema/COPD  □ Other  **Musculoskeletal**  □ RA  □ Psoriatic arthritis  □ Other  **Neurologic/psychiatric**  □ Seizures or epilepsy  □ Anxiety /depression  □ History of Guillain-Barré  □ Other  **Skin**  □ Psoriasis  □ Other  **OB/GYN**  □ Pregnant: weeks/trimester  □ Breastfeeding  □ Possible pregnancy in next 3 months  □ Other | | |
| **VACCINATION HISTORY**  **(Please bring all vaccination records to your appointment.)** | | | |
| Have you received the following immunizations?  Hepatitis A ❑ Yes When? ❑ No ❑ Not sure  Hepatitis B ❑ Yes When? ❑ No ❑ Not sure  Meningococcal ❑ Yes When? ❑ No ❑ Not sure  Measles/Mumps/Rubella ❑ Yes When? ❑ No ❑ Not sure  Polio ❑ Yes When? ❑ No ❑ Not sure  Tetanus ❑ Yes When? ❑ No ❑ Not sure  Typhoid ❑ Yes When? ❑ No ❑ Not sure  Yellow Fever ❑ Yes When? ❑ No ❑ Not sure  Japanese Encephalitis ❑ Yes When? ❑ No ❑ Not sure  Influenza ❑ Yes When? ❑ No ❑ Not sure  Other  Have you ever had an adverse reaction to an immunization? ❑ No ❑ Yes Explain: | | | |

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| **Name** | | **DOB** | **Date** |
| **CURRENT MEDICATIONS** | | | |
| **Prescription medications: List all current prescription medications** | | | |
| **Medication** | **Reason for use/medical condition** | | |
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| **Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.** | | | |
| **Product** | **Reason for use/medical condition** | | |
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| **QUESTIONS/CONCERNS** | | | |
| **Additional questions or concerns about your travel:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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