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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 □ FemaleHome 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 sureBirth 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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