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

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: _____

_____

Name	DOB	Date

CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:

_____

_____

_____

_____

_____

_____

_____

_____

Lorain County Public Health Travel Clinic

Welcome to Lorain County Public Health (LCPH) Travel Clinic. To financially plan your travel clinic appointment, please read the following carefully.

If you have insurance, contact your provider to determine if LCPH is in your network and if vaccines are a covered benefit.

Vaccines that LCPH will bill to your insurance if in network include:

- Hepatitis A
- Hepatitis B
- Tetanus/TdaP
- MMR
- Varicella
- Meningitis
- Flu
- Pneumonia

Billing your insurance does not mean that all costs will be paid. You will be responsible for all co-payments, amounts applied to deductibles and other amounts that may be stated as your responsibility by your insurance agency.

Travel-specific vaccines are not billed to your insurance. You are required to pay for them on the day of your appointment. These vaccines are:

- Yellow Fever
- Typhoid
- Japanese Encephalitis
- Cholera
- Polio
- Rabies

An insurance reimbursement form can be provided to you for travel vaccines.

Cash, check, VISA and MasterCard are accepted as payment.

A consultation fee of $50 will be collected on the day of your appointment. In addition to vaccination, you may receive prescriptions to prevent malaria and diarrhea and educational material on:

- Food & water precautions
- Insect & pest precautions
- Consular advice
- Medical summary

If you have any questions, please don't hesitate to ask.