

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 (FOR CURRENT TRIP)	Arrival Date	Departure Date

Name	DOB	Date
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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 | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Hepatitis B | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Meningococcal | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Measles/Mumps/Rubella | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Polio | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Tetanus | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Typhoid | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Yellow Fever | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Japanese Encephalitis | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Influenza | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Other _____ | | | |

Have you ever had an adverse reaction to an immunization? No Yes Explain: _____

Name	DOB	Date
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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:
