

University of Utah Medical Center  
**INTERNATIONAL TRAVEL CLINIC**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Country of birth: \_\_\_\_\_ Date of immigration to USA (if applicable): \_\_\_\_\_

**TRAVEL INFORMATION**

Departure date \_\_\_\_\_ Return date \_\_\_\_\_ Total length of trip \_\_\_\_\_

Number of people traveling with you \_\_\_\_\_ OR in your tour group \_\_\_\_\_

**ITINERARY:** (Please list countries, cities in order of travel)

<u>Country</u>	<u>City/Area</u>	<u>Country</u>	<u>City/Area</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

**Purpose of your trip:** (check all that apply)

- Business/Work       Provide medical care       Missionary       Adoption       Other \_\_\_\_\_  
 Vacation       Receive medical care       Humanitarian       Visit family/friends

**Type of travel:** (check all that apply)

- Guided/escorted       Rural       Fixed itinerary       Type of lodging: \_\_\_\_\_  
 Independent       Urban/major cities       Flexible itinerary

**Activities:** (check all that apply)

- Tour bus       Ocean/salt water       Sun exposure       Field work  
 Automobile travel       Scuba diving/snorkeling       Altitude > 8,000 ft (2500 m)       Animal contact/hunting  
 Motorcycle/bicycling       Fresh water; rivers/lakes       Caving (spelunking)       \_\_\_\_\_  
 Cruise ship travel       Rafting/kayaking       Camping/hiking

**Items that you would like to discuss:** (check all that apply)

- Altitude sickness       Seeking medical care       Risk of malaria       Food and water safety  
 Insect-borne disease       Traveler's diarrhea       Motion sickness       Jet lag  
 Risk of blood borne infections       Risk of sexually transmitted diseases       \_\_\_\_\_

**PERSONAL MEDICAL INFORMATION**

- Yes     No    Did you receive all of your childhood vaccines?  
 Yes     No    Have you ever had chicken pox disease or the vaccine series?  
 Yes     No    Are you a smoker?  
 Yes     No    Do you have a personal or family history of Guillain-Barré Syndrome?  
 Yes     No    Have you taken oral cortisone, prednisone, or other steroids, anti-cancer drugs, or had radiation treatment in the last 3 months?  
 Yes     No    Do you have any seizure or brain problems?  
 Yes     No    Have you received gamma-globulin or a blood transfusion within the past year?  
 Yes     No    Have you received a TB test in the past four weeks? If yes, when: \_\_\_\_\_  
 Yes     No    Have you ever taken anti-malarial medication? If yes, what medication: \_\_\_\_\_  
Did you tolerate it well?     Yes     No  
 Yes     No    While traveling is there a chance of having unprotected homosexual or heterosexual contact, use of needles for injection of drugs or medications, tattoos, acupuncture or a blood transfusion?  
 Yes     No    (Females only) Are you pregnant or planning on becoming pregnant? If yes, when: \_\_\_\_\_  
 Yes     No    (Females only) Are you currently breastfeeding? If yes, how old is the infant: \_\_\_\_\_

**Allergies:** (check all that apply)

- Sulfa       Erythromycin       Neomycin       Streptomycin       Polymyxin B  
 Eggs       Chickens       Baker's Yeast       Gelatin       Bee Stings  
 Other \_\_\_\_\_

**PERSONAL MEDICAL INFORMATION (cont.)**

**Past medical history:** (check all that apply)  None

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Hepatitis/liver disorders  | <input type="checkbox"/> Myesthenia gravis         | <input type="checkbox"/> Prostate problems               | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Thrombophlebitis/blood clot  | <input type="checkbox"/> Seizures/epilepsy         | <input type="checkbox"/> Kidney disease                  | <input type="checkbox"/> Heart disease/attacks |
| <input type="checkbox"/> Recurrent pneumonia  | <input type="checkbox"/> Mental/emotional disorder | <input type="checkbox"/> Irregular heart rhythms         | <input type="checkbox"/> HIV/AIDS              |
| <input type="checkbox"/> Splenectomy  | <input type="checkbox"/> Thymus disease/thymectomy | <input type="checkbox"/> Blood thinning meds             | <input type="checkbox"/> _____                 |
| <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Retinal or visual field changes |  |
| <input type="checkbox"/> Conditions treated with immunosuppressive medications; cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis. |  |  |  |

**MEDICATION INFORMATION**

*(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)*

Medication	Reason for Taking	Medication	Reason for Taking

**IMMUNIZATION INFORMATION**

Vaccine	Date of last immunization	For Office Use		Vaccine	Date of last immunization	For Office Use	
			D/D				D/D
Chickenpox* (Varicella)				MMR* (0, 1 mo) (Measles/Mumps/Rubella)			
Hepatitis A <sup>†</sup> (0, 6 mo)				PCV (Pneumo Conjugate) (2, 4, 6, 12 mo)			
Hepatitis B (0, 1, 6 mo)				Pneumococcal			
Hepatitis A & B (Twinrix) (0, 1, 6 mo) (0, 7, 21d, 12 mo)				Polio/IPV/OPV			
HIB (2, 4, 6, 12-15 mo)				Rabies (Pre-Ex 0, 7, 14-28 d) (Post-Ex 2 add'l doses req)			
HPV* (0, 2, 6 mo)				Tetanus/Diphtheria			
Influenza				Tetanus/Diphtheria/Pertussis			
Gamma globulin				Typhoid oral <sup>†</sup> (0, 2, 4, 6 d)			
Japanese encephalitis <sup>†</sup> (0, 7, 30d) (0, 7, 14d)(0,28d)				Typhoid injectable			
Meningococcal (Menactra)				Yellow Fever <sup>†</sup>			
Meningococcal (Menomune)				Zostavax* (shingles)			

**FOR OFFICE USE**

C = Completed series	L# = Lot Number	mo = month	<b><u>D/D = Discussed/declined</u></b>
Hx = History of disease	Malaria prophylaxis recommended?	d = days	1 = Not covered by insurance
V1 = Visit Date: _____	<input type="checkbox"/> Yes, _____	* Contraindicated in pregnancy	2 = Pt feels doesn't need it
V2 = Visit Date: _____	<input type="checkbox"/> No, patient at low/no risk	† Data on safety in pregnancy not available	3 = Personal beliefs
V3 = Visit Date: _____			4 = Side-effects
			5 = Get from PCP
			6 = Not enough time before travel
			7 = Will get at destination