



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Country of Birth: \_\_\_\_\_ Date of Immigration to U.S.: \_\_\_\_\_

**TRAVEL INFORMATION**

Departure Date \_\_\_\_\_ Return Date \_\_\_\_\_ Total Length of Trip \_\_\_\_\_  
NUMBER of people traveling with you \_\_\_\_\_ Or in your Tour Group \_\_\_\_\_

**ITINERARY:** (List Countries 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 TRIP:** (check all that apply)

- Business/Work       Vacation       Missionary       Adoption       Visit Family/Friends  
 Receive Medical Care       Humanitarian       Other \_\_\_\_\_

**TYPE OF TRAVEL:** (check all that apply)

- Guided/Escorted       Rural       Fixed Itinerary       Usual Tourist Areas  
 Independent       Major Cities       Flexible Itinerary       Unusual Tourist Areas

**Check any of the following ACTIVITIES that apply to your trip:**

- Provide Medical Care       Bicycling       Rafting/Kayaking       Camping  
 Field Work       Cruise Ship Travel       Swimming/Wading       Trekking  
 Animal Contact/Hunting       Ocean/Salt Water       Sun Bathing/Exposure       \_\_\_\_\_  
 Tour Bus       Scuba Diving/Snorkeling       Altitude > 8,000 ft (2500 m)  
 Automobile Travel       Fresh Water/Rivers/Lakes       Caving (Spelunking)

**Check any items you would like to discuss:**

- 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 your childhood vaccines?  
 Yes     No    Have you ever had chicken pox disease or vaccine series?  
 Yes     No    Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?  
 Yes     No    Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last three months?  
 Yes     No    Do you have any seizure or brain problems?  
 Yes     No    Have you received gamma-globulin or blood transfusions with the past year?  
 Yes     No    Have you received a TB test in the past four weeks?  
 Yes     No    Have you ever taken anti-malarial medication? If yes, what medication: \_\_\_\_\_  
Did you tolerate it well?     Yes     No  
 Yes     No    Are you at-risk for blood borne infections such as: HIV, AIDS, or Hepatitis B? (Risks include: blood transfusions, unprotected homosexual or heterosexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.)  
 Yes     No    (Females) Are you pregnant or planning on becoming pregnant? When: \_\_\_\_\_  
 Yes     No    (Females) Are you currently breastfeeding? \_\_\_\_\_

**Allergies:**

Are you allergic to any of the following?

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

**PERSONAL MEDICAL INFORMATION (con't)**

- Check if you have/had any of the following diseases or medical problems:**  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 diseases | <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"/> Psoriasis                   | <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Retinal or Visual Field Changes |  |
- Conditions treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis)
- Other: \_\_\_\_\_

**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 M) (Measles/Mumps/Rubella)			
Hepatitis A ● (0, 6 M)				PCV (Pneu. Conj.) (2, 4, 6, 12 M)			
Hepatitis B (0, 1, 6 M)				Pneumococcal			
Hepatitis A & B (Twinrix) (0, 1, 6 M) (0, 7, 21 d, 12 M)				Polio/IPV/OPV			
HIB (2, 4, 6, 12-15 M Peds)				Rabies (Pre-Ex 0, 7, 14-28 d) (Post-Ex 2 add doses req)			
HPV*				Tetanus/Diphtheria			
Influenza				Tetanus/Diphtheria/Pertussis			
Gamma Globulin				Typhoid oral ● (0, 2, 4, 6 d)			
Japanese Encephalitis ● (0, 7, 30 d) (0, 7, 14 d)				Typhoid injectable			
Meningococcal (Menactra)				Yellow Fever ●			
Meningococcal (Menomune)				Zostavax*			

**FOR OFFICE USE**

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