Newport Coast Pharmacy Travel Clinic

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Patient Travel History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____

Home Telephone No.: (____) _____ Cell Phone: (____) _____ ☐ Male ☐ Female

E-Mail Address: _____ Do you have a current passport or visa? ☐ Yes ☐ No

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Travel Specifics

Purpose of Trip: ☐ School Related Study/Work ☐ Pleasure ☐ Business ☐ Other _____

What will you be doing on this trip?_____

_____

Does your program require the completion of a medical form by a practitioner? ☐ Yes ☐ No

Are you currently enrolled in a health insurance plan that covers you while overseas? ☐ Yes ☐ No

What insurance coverage do you currently have? _____

Departure date from United States: _____ Return date to United States: _____

Countries **AND** cities to be visited in order of visits	Arrival Date	Departure Date

Have you travelled outside the United States before? ☐ Yes ☐ No

If yes, where and when? _____

Will you be…

Visiting **ONLY** urban areas? ☐ Yes ☐ No

If no, explain: _____

Staying **ONLY** in Hotels? ☐ Yes ☐ No

If no, explain: _____

Visiting friend and family? ☐ Yes ☐ No

Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains? ☐ Yes ☐ No

Working in the medical or dental field with exposure to blood or other body fluids? ☐ Yes ☐ No

Working with Exposure to animals? ☐ Yes ☐ No

Potentially having sexual contact with new partners? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No

If yes, how many packs per day?: _____

For Women Only:

Date of last menstrual period: _____ Are you, or could you possibly be pregnant? ☐ Yes ☐ No

Are you breast-feeding an infant? ☐ Yes ☐ No

Allergies

1. ☐ No known drug allergies ☐ No known food allergies
2. Have you had an allergic reaction to any of the following? (please check all that apply)

☐ Eggs
☐ Sulfa Drugs (e.g. Bactrim, Septra)
☐ Pyrimethamine
☐ Chrysanthemums
☐ Latex
☐ Quinines (Chlorowuine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], Primaquine)
☐ Antibiotics (e.g. Neomycin, Streptomycin, Pollymyxin)
☐ Thimerosal (preservative in contact lens solution)
☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin)
☐ Other: _____

Immunizations

1. Were you born in the United States? ☐ Yes ☐ No If no, where? _____
2. Have you completed the following immunizations?

Hepatitis A	☐ Yes	When: _____	☐ No	☐ Not Sure
Hepatitis B	☐ Yes	When: _____	☐ No	☐ Not Sure
HPV (Human Papilloma Virus)	☐ Yes	When: _____	☐ No	☐ Not Sure
Influenza (for current season)	☐ Yes	When: _____	☐ No	☐ Not Sure
Meningococcal Meningitis	☐ Yes	When: _____	☐ No	☐ Not Sure
MMR (Measles, Mumps, Rubella)	☐ Yes	When: _____	☐ No	☐ Not Sure
Polio Series	☐ Yes	When: _____	☐ No	☐ Not Sure
Pneumococcal (Pneumonia)	☐ Yes	When: _____	☐ No	☐ Not Sure
Tetanus	☐ Yes	When: _____	☐ No	☐ Not Sure
Typhoid	☐ Yes	When: _____	☐ No	☐ Not Sure
Varicella (or history of chickenpox)	☐ Yes	When: _____	☐ No	☐ Not Sure
Yellow Fever	☐ Yes	When: _____	☐ No	☐ Not Sure
Zoster (shingles)	☐ Yes	When: _____	☐ No	☐ Not Sure

Medical History

1. Are you using steroids, receiving radiation or other immunosuppressive chemotherapy? ☐ Yes ☐ No
2. List your current prescription medications and medical condition treated: (include birth control pills)

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

3. List regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc.)

Current Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

4. Have you been told you have any of the following medical conditions (check all that apply)?

☐ Anemia
☐ Asthma
☐ Blood Clotting Problems
☐ Cancer
☐ Depression
☐ Diabetes
☐ Ear Infections (chronic)
☐ Epilepsy/Seizures
☐ Eye Problems
☐ G6PD Deficiency
☐ Gout
☐ Hearing Problem
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Hormone Problems
☐ Immune System Deficiency
☐ Kidney Disease
☐ Liver Disease/Hepatitis
☐ Lung Disease
☐ Prostate Problems
☐ Psoriasis/Other Skin Problem
☐ Psychiatric Problems
☐ Sickle Cell Disease
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Problems
☐ Other: _____

Questions/Concerns

1. List additional questions/concerns you might have (i.e. voltage requirements, currency conversion rates, etc.) _____