300 American Street, Catasauqua, PA 18032
610-264-5471 or 1-800-325-6856
Email: pharmacy@hartzells.com

TRAVEL HISTORY FORM

Name: ______________ SSN: ____/ ____/ ____ Today's Date: ____/____/____ Date of Birth: ____/____/____ ☐ Male ☐ Female
Address: ______________ Home Phone: (___) ______ Alt Phone: (___) ______
E-Mail Address: ______________ Primary Care Doctor: ______________ Home Phone: (___) ______

TRAVEL SPECIFICS

Purpose of trip: ☐ School related study/ work What school?

☐ Pleasure ☐ Business ☐ Other:

What will you be doing on this trip?

Do you have a current passport/ visa?.. ☐ Yes ☐ No

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 and U.S. City departing from United States: ______________ ______

Return: Date and U.S. City entering upon return date to United States: ______________

If you have a detailed itinerary, please attach it so that we can review the full details of the trip.

Countries AND Cities to be visited (in order of visits)	Arrival Date	Departure Date

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

If yes, where and when? ______________

B. Will you be: Yes No

☐ ☐ Visiting ONLY urban areas? If no, explain:

☐ ☐ Staying ONLY in hotels? If no, explain:

☐ ☐ Visiting friends and family?

☐ ☐ Ascending to high altitudes (>7,000ft or 2,300 meters) in the mountains?

☐ ☐ Working in the medical or dental field with exposure to blood or body fluids?

☐ ☐ Working with exposure to animals?

☐ ☐ Potentially having sex with new partners?

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)

Item Causing Reaction	Describe Reaction (wheezing, rash, trouble breathing, etc.)
☐ Eggs	
☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin)	
☐ Antibiotics (e.g. Neomycin, Streptomycin)	
☐ Sulfa drugs (e.g. Bactrim, Septra, Gantrisin)	
☐ Chrysanthemums	
☐ Pyrimethamine	
☐ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], Primaquine)	

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☐ Thimerosal (preservative in contact lens solution)	
☐ Other: ________	

Medical History

1. Are you using steroids, receiving radiation therapy, or other immunosuppressive chemotherapy? ☐ Yes ☐ No
2. List your current prescription medications and medical condition (include birth control pills). If you need additional space, please attach a separate sheet to this form:

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

3. List regularly used non-prescription medications (over-the-counter, herbals, vitamins, homeopathic). If you need additional space, please attach a separate sheet to this form:

Regularly Used Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	
4.	
5.	

4. Have you been told that you have any of the following medical conditions? (list any others on the back)

Yes	No	Family History		Yes	No	Family History		Yes	No	Family History	
☐	☐	☐	Anemia	☐	☐	☐	G6PD Deficiency	☐	☐	☐	Lung Disease
☐	☐	☐	Asthma	☐	☐	☐	Gout	☐	☐	☐	Prostate Problems
☐	☐	☐	Blood Clotting Problems	☐	☐	☐	High Blood Pressure	☐	☐	☐	Immune System Deficiency
☐	☐	☐	Psychiatric Problems	☐	☐	☐	Heart Disease	☐	☐	☐	Psoriasis/skin disorder
☐	☐	☐	Depression	☐	☐	☐	Hearing problems	☐	☐	☐	Cancer
☐	☐	☐	Diabetes	☐	☐	☐	High Cholesterol	☐	☐	☐	Sickle Cell Disease
☐	☐	☐	Chronic/frequent ear infection	☐	☐	☐	Hormone problems	☐	☐	☐	Liver disease/ Hepatitis
☐	☐	☐	Epilepsy	☐	☐	☐	Stomach Ulcer	☐	☐	☐	Stroke
☐	☐	☐	Eye Problems	☐	☐	☐	Kidney Disease	☐	☐	☐	Thyroid Problem

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5. ***For Women Only:***
   Last normal menstrual period:
   Are you or could you be pregnant? ☐ Yes ☐ No
   Are you currently breast-feeding or will you be on the trip? ☐ Yes ☐ No

6. **Please attach a current vaccine record to this sheet.** If you do not have an updated vaccination record, please complete a Release of Records form so that we may contact your other health care providers to obtain the necessary information. **Vaccine record attached:** ☐ Yes ☐ No

7. Are there any specific concerns or questions you have about your travel that you would like answered during the consultation?
   ____
   ____

I, __ ______________(patient name), grant Hartzell's Pharmacy permission to contact my physician to obtain any necessary health information that would be relevant for this travel health consultation. I acknowledge that I have completed this form to the best of my abilities. I am aware that the Travel Health Consultation will be based on the information provided herein. I am aware that a non-refundable deposit of $30.00 (CPT 99605) will be charged up front and applied to the first 15 minutes of the consultation.

Signature: Date: