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Patient Travel History Form

Name: _____ Date of Birth: _____ Today's Date: _____
Address: _____
Home Telephone: (____) _____ Cell Phone: (____) _____ Male____ Female____
E-Mail Address: _____ Do you have a current passport or visa? Yes____ No____

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 traveled 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 friends 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

___ No known drug allergies ___ No known food allergies

Have you had an allergic reaction to any of the following? (please check all that apply)

- | | |
|--|--|
| ___ Eggs | ___ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], Primaquine) |
| ___ Sulfa Drugs (e.g. Bactrim, Septra) | ___ Antibiotics (e.g. Neomycin, Streptomycin, Polymyxin) |
| ___ Pyrimethamine | ___ Thimerosal (preservative in contact lens solution) |
| ___ Chrysanthemums | ___ Tetracyclines (Doxycycline, Minocin, Minocycline, Acromycin) |
| ___ Latex | |
| ___ Other: _____ | |

Immunizations

1. Were you born in the United States? Yes___ No___ If no, where? _____
2. Do you have the International Certificate of Vaccination (Yellow Card)? Yes___ No___
3. Have you completed the following immunizations?

Hepatitis A	Yes___ When: _____	No___	Not Sure___
Hepatitis B	Yes___ When: _____	No___	Not Sure___
HPV (Human Papillomavirus)	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.	

2. 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.	

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

- | | | |
|------------------------------|------------------------------|-----------------------------------|
| ___ Anemia | ___ G6PD Deficiency | ___ Liver disease/Hepatitis |
| ___ Asthma | ___ Gout | ___ Lung disease |
| ___ Blood clotting problems | ___ Hearing problem | ___ Prostate problems |
| ___ Cancer | ___ Heart disease | ___ Psoriasis /Other skin problem |
| ___ Depression | ___ High blood pressure | ___ Psychiatric problems |
| ___ Diabetes | ___ High cholesterol | ___ Sickle cell disease |
| ___ Ear infections (chronic) | ___ Hormone problems | ___ Stomach ulcer |
| ___ Epilepsy/Seizures | ___ Immune system deficiency | ___ Stroke |
| ___ Eye Problem | ___ Kidney disease | ___ Thyroid problems |
| Other: _____ | | |

Questions/Concerns

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