Anaheim Pro-Care Pharmacy
International Travel Health Clinic

Please complete all of the following information and then either email, fax, or mail these forms back in order to schedule your appointment

Cancellation fee: $30

A $30 fee will be charged for cancellation or rescheduling of any appointment with less than 24 hours' notice.

Today's date: _____

Name: _____ **Date of birth: _____**

Address: _____

City, State, Zip: _____

Phone number: _____ Email: _____

Physician name: _____

Physician phone/fax number: _____

Returning patient to travel health clinic? (yes/no): _____

Purpose of current travel (e.g. business, pleasure, service): _____

Briefly describe your travel plans/activities: _____

_____

Are you covered by a health insurance plan while overseas? _____

Please fill in your travel itinerary, including all dates of arrival and departure

Destination (Please List Specific City and Country)	Arrival	Departure

Will you be	**Yes**	**No**
Visiting ONLY urban areas? If no, please explain _____	□	□
Staying ONLY in hotels? If no, please explain _____	□	□
Traveling to high altitudes (> 10,000 ft. or 2,000 m)?	□	□
Handling blood/blood products or working in a hospital or clinic?	□	□
Engaging in sexual activities with a new partner?	□	□
Visiting either family or friends?	□	□
Working with wild animals?	□	□
Exposed to wild animals?	□	□

Allergies

1. No known drug allergies □ **No known food allergies** □

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

☐	**Eggs or egg products**	□	**Anti-malarials (e.g. Aralen, Larium, Malarone)**
□	**Sulfa drugs (e.g. bactrim, spetra)**	□	**Tetracyclines (minocin, doxycycline)**
□	**Antibiotics (e.g. neomycin)**	□	**Gelatin**
□	**Chrysanthemums**	□	**Other: _____**
			_____

Vaccination History:

	Yes	No	Date(s) of administration
1. Hepatitis A	□	□	**Dose 1: _____ Dose 2: _____**
2. **Hepatitis B**	□	□	**Dose 1: _____ Dose 2: _____ Dose 3: _____**
3. Tetanus	□	□	**_____**
4. Typhoid (oral, injectable)	□	□	**_____**
5. MMR	□	□	**_____**
6. Polio	□	□	**_____**
7. Meningococcal	□	□	**_____**
8. Pneumococcal	□	□	**_____**
9. Yellow fever	□	□	**_____**
10. Immune globulin	□	□	**_____**

11. Other (please list): _____

Are you currently being treated for cancer or other immunosuppressive conditions? Y/N/Not Sure
Are you currently receiving chemotherapy or other immunosuppressive medications? Y/N/Not Sure

C. Medical and Medication History (list all current medical conditions and medications)

Medical condition	Medication(s) used for condition

D. Do you or other family members have any of the following medical conditions?

Yes	No	Family History		Yes	No	Family History		Yes	No	Family History	
□	□	□	Anemia	□	□	□	G6PD deficiency	□	□	□	Lung disease
□	□	□	Asthma	□	□	□	Gout	□	□	□	Prostate disease
□	□	□	Blood disorders	□	□	□	Hearing problems	□	□	□	Psoriasis/Skin disease
□	□	□	Cancer	□	□	□	Heart disease	□	□	□	Psychiatric illness
□	□	□	Depression	□	□	□	High blood pressure	□	□	□	Sickle cell disease
□	□	□	Diabetes	□	□	□	High cholesterol	□	□	□	Stomach ulcer
□	□	□	Ear infections	□	□	□	Immune system disorders	□	□	□	Stroke
□	□	□	Epilepsy	□	□	□	Kidney disease	□	□	□	Thyroid problems
□	□	□	Eye problems	□	□	□	Liver disease	□	□	□	Other

If female, are you currently pregnant or planning on becoming pregnant? _____

If female, are you currently breast-feeding an infant? _____

What concerns relating to your travel do you have? _____

_____