MUNSON HEALTHCARE



# TRAVELER HEALTH HISTORY

Please bring this completed form and immunization records to your appointment

Name: Date of Birth: ☐ Male ☐ Female

Home Phone: Work Phone: Mobile Phone:

Home Address:

City: State: Zip:

Email:

Primary Care Physician: Phone:

Patient ID Number: Primary Insurance:

Does your insurance cover:

Health care overseas? ☐ Yes ☐ No ☐ Not sure

Medical evacuation? ☐ Yes ☐ No ☐ Not sure

Birth country:

**TRAVEL PLANS** (list additional information on back of form if needed)

**Purpose of trip** (check all that apply)

☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends or family ☐ Missionary/volunteer/humanitarian relief
☐ Work (urban, office-based, or conference) ☐ Work (rural, outdoors, or in local community)
☐ To obtain medical or dental care ☐ Other: _____

**Planned activities** (list all): _____

**Will you be**:

Visiting areas that are:

- Rural ☐ Yes ☐ No ☐ Not sure
- Urban ☐ Yes ☐ No ☐ Not sure
- Primitive or remote ☐ Yes ☐ No ☐ Not sure

Ascending to high altitudes (8,000 feet or higher)? ☐ Yes ☐ No ☐ Not sure
Working with potential exposure to body fluids (e.g., medical or dental work)? ☐ Yes ☐ No ☐ Not sure
Working with exposure to animals? ☐ Yes ☐ No ☐ Not sure
Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

**Accommodations** (check all that apply)

☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise Ship ☐ Private home (w/locals) ☐ Private home (w/relatives)
☐ Private home (expatriate or high-end) ☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/hostel
☐ Other: _____

Previous international travel (year/destination): _____

_____

| Countries and cities in order of visit | Arrival Date | Departure Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Name: | Date of Birth: | Date: |
|---|---|---|

## HEALTH HISTORY (check all that apply)

### Allergies
- ☐ Antibiotics (e.g., penicillin, sulfa):_____
- ☐ Other medications: _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other: _____
- ☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset):_____

### Cancers/blood disorder
- ☐ Coagulation disorder
- ☐ History of cancer or blood disorder
- ☐ Other: _____

### Cardiovascular
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial Fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other: _____

### Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other: _____

### GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other: _____

### Immune system
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medication or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, rituximab, leflunomide)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - Most recent CD4: _____
  - Most recent viral load: _____
- ☐ Organ, bone marrow, stem cell transplant: _____
- ☐ Other: _____

### Kidneys
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other:_____

### Lungs
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other: _____

### Musculoskeletal
- ☐ RA
- ☐ Psoriatic arthritis
- ☐ Other: _____

### Neurological/psychiatric
- ☐ Seizures or epilepsy
- ☐ Anxiety/depression
- ☐ History of Guillain-Barre Syndrome
- ☐ Other:_____

### Skin
- ☐ Psoriasis
- ☐ Other:_____

### OB/GYN
- ☐ Pregnant _____ weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other:_____

## VACCINATION HISTORY
**(please bring all vaccination records to your appointment)**

**Have you received the following immunizations?**

| | | | |
|---|---|---|---|
| ☐ Hepatitis A | ☐ Yes when:_____ | ☐ No ☐ Not sure | ☐ Other: |
| ☐ Hepatitis B | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |
| ☐ Meningococcal | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |
| ☐ Measles/Mumps/Rubella | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |
| ☐ Polio | ☐ Yes when:_____ | ☐ No ☐ Not sure | Have you ever had an adverse reaction |
| ☐ Tetanus | ☐ Yes when:_____ | ☐ No ☐ Not sure | to an immunization? ☐ Yes ☐ No |
| ☐ Typhoid | ☐ Yes when:_____ | ☐ No ☐ Not sure | Explain: |
| ☐ Yellow Fever | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |
| ☐ Japanese Encephalitis | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |
| ☐ Influenza | ☐ Yes when:_____ | ☐ No ☐ Not sure | _____ |

| Name: | Date of Birth: | Date: |
|---|---|---|

## CURRENT MEDICATIONS

**Prescription medications: List all current prescription medications**

| Medication | Reason for use/medical condition |
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**Non-prescription products: List all current over-the-counter, herbal, homeopathic products, vitamins, supplements etc.**

| Product | Reason for use/medical condition |
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## QUESTIONS/CONCERNS

**Additional questions or concerns about your travel:**

Submit