

TRAVELER HEALTH HISTORY

Please bring this completed form and immunization records to your appointment

Name:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure		
Medical evacuation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____
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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?

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Measles/Mumps/Rubella | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Typhoid | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Yellow Fever | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Japanese Encephalitis | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No <input type="checkbox"/> Not sure | _____ |

Have you ever had an adverse reaction to an immunization? Yes No
 Explain: _____

Name:	Date of Birth:	Date:
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CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List all current over-the-counter, herbal, homeopathic products, vitamins, supplements etc.

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:
