TRAVELER HISTORY FORM

Complete this form and bring it to the clinical appointment along with all immunization records.

Name:____________________________________ DOB___________________ ◻ Male ◻ Female
Home Phone:___________________ Work Phone:_________________ Mobile Phone: _________________
Home Address: ____
City:____________________________ State:_______________________ Zip Code:_____________________
Birth Country: ___________________Email: ____
Primary Care Physician: ____ City: ________________________

Does your insurance cover:

Health care overseas? ◻ Yes ◻ No ◻ Not Sure
Medical evacuation? ◻ Yes ◻ No ◻ Not Sure

Previous international travel in last 2 years? ◻ Yes ◻ No
(list country and year) ____
____

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

Purpose of trip (check all that apply)
◻ Missionary/Volunteer/humanitarian relief ◻ Vacation ◻ Educational/research
◻ Work (urban, office-based, or conference) ◻ Adoption ◻ Visit friends or family
◻ 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 ft 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 ◻ Up-scale camp/lodge
◻ Private home (with locals) ◻ Private home (with locals) ◻ Private home (expatriate or high-end)
◻ Dormitory/hostel ◻ Primitive camping ◻ Other: _______________________________________
Total duration of trip: _____________

ITINERARY

City and Country in order of visit this trip	Arrival Date	Departure Date

Allergies
☐ Antibiotics (e.g., penicillin, sulfa) ____________________
☐ Other medications ________________________________
☐ Egg-*Severe* ____________________________________
☐ Latex ____
☐ Gelatin-*Severe*
☐ Yeast
☐ Bees/ wasps
☐ Seasonal
☐ Other ____
☐ Side effects/reactions from previous medications (e.g., Nausea, dizziness, stomach upset):__________________

Cancer/Blood Disorder _____________________________
☐ blood disorder
☐ Coagulation disorder
☐ History of cancer
☐ History of Malaria
☐ G6PD deficiency
☐ Radiation therapy in last 3 months
☐ Chemotherapy in last 3 months
☐ Other ____

Cardiovascular
☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
☐ Implanted pacemaker or automatic defibrillator
☐ Heart attack – when________________________________
☐ 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 medications or treatments within last 3 Months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
☐ Spleen removed
☐ Thymus disease or thymectomy
☐ DiGeorge syndrome
☐ Myasthenia gravis
☐ HIV/AIDS
- Most recent CD4: ______________________________
- Most recent viral load: ___________________________

☐ Organ, bone marrow, stem cell transplant _________________
☐ Other ____

Kidneys
☐ Dialysis
☐ Kidney insufficiency/ CKD
☐ Other ____

Lungs
☐ Asthma
☐ Emphysema/COPD
☐ High altitude pulmonary edema
☐ Other ____

Musculoskeletal
☐ RA
☐ Psoriatic arthritis
☐ Other ____

Neurological/psychiatric
☐ Seizures or epilepsy
☐ Anxiety/ depression
☐ History of Guillain- Barré syndrome
☐ High altitude mountain sickness
☐ Other ____

Skin
☐ Psoriasis
☐ Other ____

OB/GYN
☐ Pregnant: __________________weeks/trimester
☐ Breastfeeding
☐ Possible pregnancy in next 3 months
☐ Other ____

Traveler's Health Clinic of North Alabama

caring for the international traveler

NAME	DOB	DATE

VACCINATION HISTORY

(Please bring all vaccination records to your appointment)

Have you received the following immunizations?

Hepatitis A	□ Yes When? _______________	□ No	□ Not Sure
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
Tetanus	□ Yes When? _______________	□ No	□ Not Sure
Typhoid	□ Yes When? _______________	□ No	□ Not Sure
Yellow Fever	□ Yes When? _______________	□ No	□ Not Sure
Japanese Encephalitis	□ Yes When? _______________	□ No	□ Not Sure
Influenza	□ Yes When? _______________	□ No	□ Not Sure
Rabies	□ Yes When? _______________	□ No	□ Not Sure
Varicella (Chickenpox)	□ Yes When? _______________	□ No	□ Not Sure
Pneumonia	□ Yes When? _______________	□ No	□ Not Sure
DPT (Pertussis)	□ Yes When? _______________	□ No	□ Not Sure
Cholera	□ Yes When? _______________	□ No	□ Not Sure
Other	□ Yes When? _______________	□ No	□ Not Sure

Have you ever had an adverse reaction to an immunization? □ Yes □ No

Explain: ______________________

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Current Medications

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

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

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

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