



Travel Health Clinic Pre-Travel Health Consultation and History Form

Personal Information:

Traveler's Name: _____

Date of Birth _____ Male Female

Address: _____

Telephone: Home _____ E-mail: _____
 Work _____ Cell: _____

Country of Birth: _____ Citizenship _____

Trip Information:

Date of Departure from home : _____ Return date/length of trip: _____

Have you traveled internationally in the past? Yes If yes, Where? No

Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____

Destination: Urban Rural Remote At High Altitude Beach

Is this a fixed itinerary? Yes No Unsure

Purpose of trip: (check all that apply)
 Vacation Medical care Business
 Education Adoption Volunteer/Humanitarian
 Visiting Friends and/or Relatives Long-stay traveler

Organized tour? Yes No Partly
 Explain: _____

Accommodations: Hotel Hostel Staying with locals/family/friends
 Rented House/Apt Camping Cruise Ship/Boat

Planned Activities: (check all that apply)

Air Travel Biking Hiking Snorkeling Swimming
 Rafting Boating Scuba Climbing/Trekking
 Contact with Animals Cave/spelunking Public Transportation (bus, train, etc)
 Visiting schools, hospitals or orphanages Health Care Worker Occupational exposure
 Other: _____

Have you obtained travel medical evacuation insurance? Yes No

Health History:

Physician's Name:

Telephone:

Address:

Do you have any chronic health problems for which you take medication on a regular basis or see a physician ?

Yes [] No []

If yes, please explain: _____

Are you currently under the care of a physician for any health problem: Yes [] No []

If yes, please explain: _____

Do you currently have or have a past history of:

Antidepressant or psychiatric medication use _____ Yes [] No []

Depression, anxiety, panic attacks _____ Yes [] No []

Psoriasis (skin disease) _____ Yes [] No []

Seizures or convulsions _____ Yes [] No []

Cardiac conduction defect, have a pacemaker _____ Yes [] No []

Heart disease or surgery _____ Yes [] No []

Respiratory (lung) disease _____ Yes [] No []

Muscle or bone problems _____ Yes [] No []

Intestinal problems including heartburn or reflux _____ Yes [] No []

Immune disorder (chemotherapy, HIV, bone marrow or organ transplant,
rheumatoid arthritis treatment) _____ Yes [] No []

Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome) _____ Yes [] No []

History of altitude illness _____ Yes [] No []

Surgery or hospitalization in past 3-5 years _____ Yes [] No []

Have you had any transfusions or blood products in the past 5 years? _____ Yes [] No []

Have you ever had Hepatitis (liver infection)? _____ Yes [] No []

Has your spleen been removed? _____ Yes [] No []

Do you drink alcohol regularly? _____ Yes [] No []

Do you smoke? _____ Yes [] No []

Have you ever had a TB test? _____ Yes [] No []

History of tendonitis / Achilles' heel rupture _____ Yes [] No []

Have you ever had a convulsion, seizure, epilepsy or neurologic condition? Yes [] No []

Other medical problem _____ Yes [] No []

Please explain any "yes" answers:

Allergies:

Medication(s) Yes [] No [] If yes, list: _____

Reaction to vaccine Yes [] No [] If yes, list: _____

Egg or other food allergies Yes [] No [] If yes, list: _____

Environmental Yes [] No [] If yes, list: _____

(pollens, dust, hay fever, etc.)

Animals Yes [] No [] If yes, list: _____

Bee stings Yes [] No []

Have you ever experienced anaphylaxis (severe allergic reaction)? Yes [] No []

If "Yes" please describe _____

Medications:Please list all prescribed and over-the-counter medications and supplements you use:

Medication or supplement:

Reason for use:

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Immunization History:

Immunization	Yes	Date(s) Received	No	Not Sure	Had the Disease
Tetanus-Diphtheria Vaccine or Tdap					
Measles Mumps Rubella (2 doses)					
Typhoid, injectable or oral					
Influenza					
Hepatitis A – 1 st dose					
2 nd dose					
Hepatitis B – 1 st dose					
2 nd dose					
3 rd dose					
Polio -- childhood series					
Polio -- adult dose or booster					
Chicken pox-varicella (2 doses)					
Meningitis (Menomune or Menactra)					
Rabies (3 doses)					
Japanese Encephalitis (3 doses)					
Yellow Fever					
Pneumococcal					
Other vaccines—please list					

Women:

Are you currently or are you trying to become pregnant?

Yes [] No []

Any risk of an unplanned pregnancy?

Yes [] No []

Are you breastfeeding?

Yes [] No []

What form of contraception do you use? _____

Other:

Please tell us any additional information that you believe is important for us to know as you prepare for your trip:

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature _____ Relationship if minor _____ Date _____

Reviewed by: _____ Date _____