## TRAVELER HISTORY FORM

Complete this form and submit prior to your appointment being scheduled.

Name:_____DOB:_____

Home Phone:_____Work Phone:_____Mobile Phone: _____

Home Address: _____

City:_____State:_____Zip:_____

Email:_____

Primary care provider: _____

Birth country: _____

**TRAVEL PLANS** (attach complete travel itinerary and additional information if available)

**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 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 ☐ Private home (with locals) ☐ Private home (with relatives)

☐ Private home (expatriate or high-end) ☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/ hostel

☐ Other _____

**Flight Information**

Flight plan: _____

Layover locations (hours):_____

Will you be leaving the airport during the layover? ☐ Yes ☐ No ☐ Not sure

**Previous international travel (year/destination):** _____

| List upcoming travel including countries and cities in order of visit | Arrival Date | Departure Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Name | DOB | 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 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
- ☐ 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 _____

**Neurologic/psychiatric**
- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Other _____

**Skin**
- ☐ Psoriasis
- ☐ Other _____

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

## VACCINATION HISTORY
**(Please have all vaccination records available during 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 |

Other: _____

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

_____

| Name | DOB | Date |
|---|---|---|

**CURRENT MEDICATIONS**

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

| Medication | Reason for use/medical condition |
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**Non-prescription products: List 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:**