HEALTH
TRAVELER HISTORY FORM
Complete this form and bring it to the clinic appointment along with all immunization records.

Name: _____ DOB: _____ ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

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

Date leaving US:_____**Duration of Travel:**_____

Purpose of trip (check all that apply)
☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends or family ☐ Missionary/volunteer/humanitarian relief
☐ Work_____
☐ 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/relatives)

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

☐ Other _____

Previous international travel (year/destination): _____

_____

Itinerary

Include ANY stopovers in Africa or South America

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 bring all vaccination records to your appointment.)

Did you complete all routine/required childhood vaccines ❑ Yes ❑ No

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

WARNING - if you use any form of Cannabis, be advised it is illegal in many foreign countries and you could be detained

What Pharmacy do you use_____

Location of the Pharmacy_____

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:

_____

_____

_____

_____

_____

_____

_____

_____