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: _____

Primary care physician:_____

Phone: _____

Patient ID#_____Primary insurance: _____

Does your insurance cover:

Health care overseas? ☐ Yes ☐ No ☐ Not sure

Medical evacuation? ☐ Yes ☐ No ☐ 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 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 _____

Previous international travel (year/destination): _____

_____

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.)

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

Non-prescription products: List 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:

CLINIC DOCUMENTATION FORM
(Clinician completes this form at time of appointment.)

Name	DOB	Date

Itinerary

Departure Date	Length of trip	Purpose of trip	Urban / Rural / Both

VACCINATION HISTORY (review with traveler)

Vaccine	Date	Date	Date	Date	Date
Cholera (oral)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hepatitis A	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hepatitis B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hepatitis A/B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
HPV (indicate: 9-valent, 4 valent, or 2-valent)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Immune globulin	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Japanese encephalitis (cell based; available since 2009)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Japanese encephalitis (mouse-brain; available pre-2009)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Measles/mumps/rubella	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Meningococcal (quadrivalent conjugate)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Meningococcal (quadrivalent polysaccharide)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Meningococcal (monovalent B)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Pneumococcal conjugate (PCV13)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Pneumococcal polysaccharide (PPSV23)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Polio primary series	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Polio adult booster (1 dose)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Rabies pre-exposure	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Rabies post-exposure	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
TBE	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Td series	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Tdap	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Typhoid (IM)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Typhoid (oral)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Yellow Fever	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Zoster (shingles)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other:					

Name	DOB	Date

MALARIA MEDICATION HISTORY

Antimalarials that the traveler has used in the past (check all that apply)

☐ Chloroquine
☐ Doxycycline
☐ Malarone or generic (atovaquone/proguanil)
☐ Mefloquine
☐ Coartem
☐ Primaquine

Side effects experienced: _____

TEACHING CHECKLIST

Date done	Brief review

Travax handouts given to the patient (check all that apply)

VACCINE-PREVENTABLE DISEASES

☐ Cholera
☐ Hepatitis A
☐ Hepatitis B
☐ Herpes Zoster
☐ Human Papillomavirus
☐ Influenza
☐ Influenza Antivirals Handout
☐ Japanese Encephalitis
☐ Measles, Mumps, Rubella
☐ Meningococcal Meningitis
☐ Pneumococcal
☐ Polio
☐ Rabies
☐ Tetanus, Diphtheria, Pertussis
☐ Tick-Borne Encephalitis
☐ Typhoid Fever
☐ Varicella
☐ Yellow Fever

OTHER INFECTIOUS DISEASES

☐ African Trypanosomiasis
☐ Avian Influenza
☐ Influenza Antivirals Handout
☐ Chikungunya
☐ Dengue
☐ Ebola Virus Disease
☐ Leishmaniasis
☐ Leptospirosis
☐ Malaria
☐ MERS Coronavirus
☐ Rickettsial Infections
☐ Schistosomiasis
☐ Sexually Transmitted Infections
☐ Tick-Borne Diseases
☐ Traveler's Diarrhea

HEALTH & SAFETY

☐ Air Travel
☐ Altitude Illness
☐ Cruise Ship Travel
☐ Food and Beverage Precautions
☐ Insect Precautions
☐ Traveler's Thrombosis
☐ Treating Water

COUNTRY HANDOUTS: _____

_____

OTHER:

_____

_____

ADDITIONAL NOTES:

_____

_____

_____

Health care provider signature and printed name	Date
_____ / _____	