TRAVEL HEALTH SERVICES, LLC

Pre-Travel Form

PERSONAL DATA (please print clearly)

Name: _____ Date: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (____)_____ Cell: (____)_____ Work: (____)_____

Birthdate: _____ Sex: ( ) M, ( ) F Weight if < 100 lbs_____ Employer:_____

Emergency Contact/ relationship: _____Phone:(___)_____

Referred by: ( )Physician_____, ( )Website, ( )Health Dept., ( )Friend/Family, ( )Other_____

TRAVEL INFORMATION

List all travel dates and countries in order of dates traveling:

1. Date: _____ From: _____ To: _____ Length of stay:_____
3. Date: _____ From: _____ To: _____ Length of stay: _____
4. Date: _____ From: _____ To: _____ Length of stay: _____
5. Date: _____ From: _____ To: _____ Length of stay: _____

Reason for Travel: ( )Business, ( )Tourist, ( )Student, ( )Missionary, ( )Other_____

Accommodations: ( )Hotel, ( )Family/Friends Home, ( )Cruise, ( )Other_____

Do you plan to visit only tourist's areas or major cities? ( ) Yes ( ) No

Do you plan to visit rural areas? ( ) Yes ( ) No

Do you plan to visit rural areas during evening or nighttime hours? ( ) Yes ( ) No

Do you plan to go hiking or backpacking? ( ) Yes ( ) No

Do you plan to travel to high altitudes? ( ) Yes ( ) No

Do you plan to go swimming? ( ) Yes ( ) No

If yes: ( )Chlorinated Pool, ( )Fresh Water Lake or Stream, ( )Ocean

Do you plan to scuba dive? Certified? ( ) Yes ( ) No.

If yes: When is air travel scheduled after the first dive?_____

MEDICATION AND ALLERGY INFORMATION

List Current Medications (including oral contraceptives and blood pressure medicine): _____

_____

_____

Please check if allergic to any of the following medications: ( )Penicillin, ( )Azithromycin, ( )Cipro, ( )Sulfa, ( )Gentamycin, ( )Streptomycin, ( )Neomycin, ( )Polymixin, ( )Amphotericin B, ( )other_____

Please check if allergic to any of the following vaccine components: ( )thimerisol / mercury, ( )phenol, ( )aluminum hydroxide, ( ) 2-phenoxyethanol, ( ) formaldehyde, ( ) aluminum, ( )chlortetracycline, other_____

Please check if allergic to any of the following: ( )eggs, ( )yeast, ( )gelatin, ( )latex, ( )animal protein, ( )feathers, ( )bee stings, ( )lactose, ( )other_____

Name: _____ Date: _____

Question	Yes	No	Question	Yes	No

Do you have a medical condition that warrants regular medication or physician follow-up? If yes, please list:			Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy?		
Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?			Do you, or any person you are in close contact with, have cancer, leukemia, HIV/AIDS, or any other auto immune problem?		
Do you have high blood pressure? Are you on medication?			Do you have severe kidney problems?		
Do you have bleeding problems, take coumadin or blood thinners or aspirin?			Do you have G6PD deficiency? If yes, you should avoid certain anti-malaria medications		
Do you have lung disease, asthma, chronic bronchitis, emphysema, or shortness of breath?			Do you have an active nerve condition? Do you have a history of seizures or Gullian-Barre?		
Do you have a stomach or bowel condition, such as irritable bowel or frequent constipation or diarrhea? Do you use medication to reduce stomach acid?			Have you had your thymus gland removed, or problems with your thymus, such as myasthenia gravis, DiGeorge Syndrome or thymoma?		
Do you have any skin condition such as psoriasis, eczema or shingles?			Have you ever fainted from an injection or from having your blood drawn?		
Do you experience insomnia or nightmares?			Are you sick today?		
During the past three months, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin or Rho-gam?			Have you ever had a serious reaction after receiving a vaccination, such as hives, rash, wheezing, difficulty breathing, or shock?		
Do you have diabetes? If yes, do you take insulin? Yes____ No__			Do you have a history of depression or psychiatric disorders?		
Have you ever tested positive for tuberculosis?			Have you received any vaccinations in the past 4 weeks? If yes, please list:		
When at altitudes above 6,000 feet, have you ever had headache, dizziness or felt short of breath?			<u>Women only</u>: Are you pregnant or plan to get pregnant in the next 3 months?		
Have you had hives or urticaria?			Have you ever taken malaria pills? If yes, did you have any side-effects?		

PREVIOUS IMMUNIZATIONS OR HISTORY OF THE DISEASE. Print "c" for childhood series completed or enter year vaccinated or ill.

Chicken Pox	Immune Globulin	Polio	Measles, Mumps, Rubella
Flu	Pneumonia	Meningitis	Tetanus/diphtheria/pertussis
Hepatitis A	Hepatitis B	Rabies	Japanese Encephalitis
Yellow Fever	Typhoid	Cholera	

The above information is accurate to the best of my knowledge. I understand that insurance may not cover travel immunization services and I am responsible for all fees due at time of service. Travel Health Services is not a Medicare provider and does no insurance or filing of claims. Payment is due at the time of service by credit card, cash or check. I understand that I will be given an immunization record with all vaccines received and that I am responsible for keeping this in a safe place and keeping records up to date. Inactive records are kept on file for 3 years. Your files are confidential.

May we send your primary care physician a copy of your immunization record? ( ) Yes ( ) No

Physician's name & address: _____

Traveler/patient signature: _____ Date: _____

Travel Health Nurse: _____ Date: _____