Print Form

Chest, Infectious Diseases and
Critical Care Associates, P.C.

CIC Physician: _____
Acct #: _____
Date: _____

TRAVEL MEDICINE CLINIC
TRAVEL HISTORY FORM

Please fill in as best you can and bring with you for your appointment at the Travel Clinic. Bring any immunization records with you. Please check yes or no for each question asked. If yes, please provide date.

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Address: _____

Telephone: _____ City, St, ZIP: _____

Family Doctor: _____

Address: _____

City, State, ZIP: _____

2. MEDICAL HISTORY

Have you ever had:

hepatitis A	☐ Yes	☐ No	_____	leukemia	☐ Yes	☐ No	_____
hepatitis B	☐ Yes	☐ No	_____	lymphoma	☐ Yes	☐ No	_____
cancer	☐ Yes	☐ No	_____	seizures	☐ Yes	☐ No	_____
a mental illness	☐ Yes	☐ No	_____	convulsions	☐ Yes	☐ No	_____
a psychiatric problem	☐ Yes	☐ No	_____	epilepsy	☐ Yes	☐ No	_____

Any problems with your immune system?
☐ Yes ☐ No _____

Current Medications:

List Medications and Dosage
(Please include inhalers, nebulized treatments, patches, herbal supplements, & vitamins)

_____
_____
_____

Allergies:

_____
_____
_____

Military Service:
When: _____
Where: _____

Foreign Travel in the past:
☐ Yes ☐ No

FOR WOMEN:

Are you:
Pregnant ☐ Yes ☐ No
Nursing ☐ Yes ☐ No

Are you planning a pregnancy during this trip or within the next three months?
☐ Yes ☐ No

Birth control if use:
(some medications affect BCPs) _____

3. IMMUNIZATIONS IN PAST

Call your mother and doctor if possible.

1) Tetanus or DPT	☐ Yes	☐ No	_____
2) Polio	☐ Yes	☐ No	_____
3) Measles	☐ Yes	☐ No	_____
4) Mumps	☐ Yes	☐ No	_____
5) Rubella	☐ Yes	☐ No	_____
6) Haemophilus	☐ Yes	☐ No	_____
7) Influenza	☐ Yes	☐ No	_____
8) Pneumococcal	☐ Yes	☐ No	_____
9) Hepatitis B (three shots over 6 months)	☐ Yes	☐ No	_____
10) Immune Globulin Gamma Globulin	☐ Yes	☐ No	_____
11) Meningococcal	☐ Yes	☐ No	_____
12) Yellow Fever	☐ Yes	☐ No	_____
13) Cholera	☐ Yes	☐ No	_____
14) Typhoid ☐ Shot ☐ Pills	☐ Yes	☐ No	_____
15) Japanese encephalitis	☐ Yes	☐ No	_____
16) Rabies	☐ Yes	☐ No	_____
17) Plague vaccine	☐ Yes	☐ No	_____
18) Hepatitis A	☐ Yes	☐ No	_____
19) Varicella vaccine	☐ Yes	☐ No	_____

Have you ever had a serious reaction to a vaccine?

_____

_____

4. HOUSEHOLD INFORMATION

Has anyone living in your household ever been diagnosed with:

leukemia	☐ Yes	☐ No	_____
lymphoma	☐ Yes	☐ No	_____
cancer	☐ Yes	☐ No	_____
AIDS	☐ Yes	☐ No	_____
had a transplant	☐ Yes	☐ No	_____

5. TRAVEL PLANS

List all countries you will be in even if only to change planes.

_____

_____

Departure Date: _____ Return Date: _____

What will you be doing on your trip? (Touring, work, health care, etc.)

_____

_____

Where will you be staying? (Local home, hotel, camping, etc.)

_____

_____

Have you received any recommendations as to what Immunizations you need?

_____

_____

Where did you hear about our Travel Medicine services?

_____

_____

_____

Person completing form Date