Date:_____

# Travel History Form

Name:_____DOB:_____Marital Status:_____Sex (circle): M F

Telephone: Home:_____Work:_____Mobile:_____

Home Address:_____

City:_____State:_____Zip:_____E-mail:_____

Who is your primary care physician?_____Telephone:_____

Employer:_____Primary Insurance:_____

Does your insurance cover: Health care overseas? ❑ Yes ❑ No ❑ Not sure Medical evacuation? ❑ Yes ❑ No ❑ Not sure

## Travel Plans

(List additional information on back of form if needed.)

Purpose of trip (check all that apply): ❑ Vacation ❑ Business ❑ Study ❑ Other: _____

Planned activities: _____

| Will you be: | Yes | No | |
|---|---|---|---|
| | ❑ | ❑ | Visiting ONLY urban areas? If no, explain:_____ |
| | ❑ | ❑ | Visiting friends and/or family? |
| | ❑ | ❑ | Ascending to high altitudes? |
| | ❑ | ❑ | Working with potential exposure to bodily fluids (e.g., medical or dental work)? |
| | ❑ | ❑ | Working with exposure to animals? |
| | ❑ | ❑ | Potentially having new sexual partners? |

| Countries and Cities (in order of visits) | Arrival Date | Departure Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Accommodations (check all that apply):
❑ Resorts or Large Hotels ❑ Small Hotels ❑ Cruise Ship ❑ Private Home ❑ Camp ❑ Dormitory
❑ Youth Hostel ❑ Other (specify)_____

Have you traveled outside the United States before? ❑Yes ❑ No
If yes, when and where? _____

## Health History

Medical Conditions (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, psychiatric illnesses): _____

_____

Surgical History:

Allergies (include medications, foods such as eggs, and environmental allergens such as ragweed):_____

_____

Intolerances or other reactions (include side effects from previous medications, such as nausea, constipation, sleepiness, dizziness, stomach upset, etc.):_____

_____

## Vaccination History

Were you born in the United States? ❑ Yes ❑No If no, where? _____

Have you received the following immunizations?

| | | | | |
|---|---|---|---|---|
| Hepatitis A | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Hepatitis B | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| HPV | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Influenza | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Japanese Encephalitis | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Meningococcal (Meningitis) | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Measles/Mumps/Rubella | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Pneumococcal (Pneumonia) | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Polio | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Rabies | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Tetanus | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Typhoid | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Varicella (Chicken Pox) | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Yellow Fever | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |
| Zoster (Shingles) | ❑ Yes | When? _____ | ❑ No | ❑ Not Sure |

Other: _____

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

## Medications

Are you currently using corticosteroids, receiving cancer treatment, or other immunosuppressive therapy? ❑ Yes ❑ No

**Prescription Medications:** List all current prescription medications and condition treated (include birth control pills):

| Prescription Medications | Reason for Use/Medical Condition |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Nonprescription products:** List all over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.)

| Nonprescription Medications | Reason for Use/Medical Condition |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Women Only**

Are you pregnant now, or do you suspect that you might be pregnant? ❑ Yes ❑ No

Do you have plans to get pregnant in the next 6 months? ❑ Yes ❑No

Date of your last menstrual period: _____

**Questions/Concerns:**

List any additional questions or concerns you have about your travel:

_____

_____

_____

_____