Travel Medication Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

PATIENT INFORMATION

Date _____/_____/________ Date of Birth _____/_____/________ Age_____

First Name____ Last Name ___________________________

Gender: Male / Female

Street Address ____

Phone ( ) ________________________ Email Address _______________________________________

Healthcare Provider Name _________________________ Phone ( ) ________________ Fax ( ) _______________

Do you have health insurance? Yes / No Insurance Provider Name ______________________________

Any allergies to medications? Yes / No If yes, please list _____________________________________

TRAVEL SPECIFICS

Purpose of Trip: ____

Activities: ____

Departure Date: _________________ Return Date: _________________

Countries AND Cities to be Visited (In Order of Visits)	Arrival Date	Departure Date

Have you traveled outside the United States before? □ Yes □ No

If yes, where, and when?

____

____

1.	Will you be ONLY using airplane as your mode of transportation If no, explain: ____	□ Yes □ No □ Not sure
2.	Will you be ONLY visiting major cities? If no, explain: ____	□ Yes □ No □ Not sure
3.	Will you be ONLY staying in hotels? If no, explain: ____	□ Yes □ No □ Not sure
4.	Will you be visiting friends and family?	□ Yes □ No □ Not sure
5.	Will you be ascending to high altitudes? (> 7,000 ft or 2,300 meters) in the mountains	□ Yes □ No □ Not sure
6.	Will you be working in the medical or dental field with exposure to blood or bodily fluids?	□ Yes □ No □ Not sure

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ALLERGIES

□ No known drug allergies □ No known food allergies

Drug Allergies: ____

Food Allergies: ____

VACCINE MEDICAL INFORMATION

Please complete the table below ***(please bring your vaccination record to the pre-travel consult)***

Vaccinations	Yes – *(Enter vaccination date below)*	No	Not Sure
COVID (Manufacturer):________________	Dose 1: 2:		
Hepatitis A	Dose 1: 2:		
Hepatitis B	Dose 1: 2: 3:		
Influenza			
Japanese Encephalitis			
Meningococcal Meningitis	Dose 1: 2:		
MMR (Measles, Mumps, Rubella)	Dose 1: 2:		
Pneumonia	PPSV23: PCV13:		
Polio (Adult Booster)			
Rabies			
Shingles			
Tetanus (Tdap/Td/DTaP/DT)			
Typhoid (Oral / Shot)			
Varicella			
Yellow Fever			
Other:			
Other:			

MEDICAL HISTORY

List your current prescription medications and medical conditions treated (include birth control pills and anti-depressants):

Current Medical Conditions:____

____

Current Prescription Medications:____

____

Regularly used Non-Prescription Medications (over the counter, herbal, homeopathic, vitamins, and supplements including those purchased at health-food stores):____

7.	Are you currently using steroids?	□ Yes □ No □ Not sure
8.	Are you currently receiving radiation therapy?	□ Yes □ No □ Not sure
9.	Are you currently receiving immunosuppressive therapy?	□ Yes □ No □ Not sure
10.	Are you pregnant or are you planning to become pregnant within the next year?	□ Yes □ No □ Not sure
11.	Are you currently breast-feeding?	□ Yes □ No □ Not sure

QUESTIONS/CONCERNS

Please list additional questions or concerns that you might have regarding your travel:

____

____

Signature: ____ Date: _______________