Insert organization logo/letterhead

ID:_____
Date:_____

Travel History Form

Name:_____ DOB:_____ Sex (circle): M F

Telephone: Home: _____ Work: _____ Mobile:_____

Home Address:_____

City:_____ State:_____ ZIP:_____ Email: _____

Who is your primary care physician?_____ Telephone: _____

ID#: _____ 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 (8,000 feet or higher)?
	❑	❑	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 visit	Arrival Date	Departure Date

Accommodations: (Check all that apply.)
_____Resorts or large hotels ____Small hotels ____Cruise Ship ____Private Home ____Camp ____Dormitory
____Youth Hostel _____Other (list)_____

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, etc) _____

_____

Surgical History:

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

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

Insert organization logo/letterhead

ID:_____
Date:_____

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
Meningococcal Meningitis	❑ 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? ❑ 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 Medication	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 become pregnant in the next 3 months ❑ Yes ❑ No
Date of your last menstrual period: _____

Questions/Concerns:

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