Pre-Travel Health Consultation and Health Form

Traveler: _____ Home Phone: _____

Date of Birth: _____ Work Phone: _____

Address: _____ Cell Phone: _____

_____ Email: _____

_____ Sex: M F Citizenship: _____

Date Form Completed: _____ Country of Birth: _____

Physician: _____ Form Completed by: _____

Trip Information

Itinerary: Please give ALL countries & cities to be visited, including stopovers, in order to be visited and time planned to spend in each place. Attach Itinerary if available. (Add sheet if needed)_____

_____

_____

_____

_____

Date of Departure from Home: _____

Return date/Length of Trip: _____

Have you traveled internationally in the past? Y N

Where: _____

_____

_____

_____

_____

Do you intend to travel frequently in future? Y N Maybe

Destination: ☐ Urban ☐ Rural ☐ Remote ☐ High Altitude ☐ Beach

Purpose of Trip: *(Check all that apply):*

☐ Medical Care ☐ Business ☐ Long-Stay Traveler ☐ Volunteer/Humanitarian

☐ Adoption ☐ Education ☐ Vacation ☐ Visiting Friends/Relatives

Organized Tour: Y N Partly Details: _____

Accommodations: ☐ Hotel ☐ Camping ☐ Rented House/Apt

☐ Hostel ☐ Cruise/Boat ☐ Staying with Locals/Family/Friend

Will You Be Traveling Alone? Y N Who are you traveling with? _____

Planned Activities: *(Check all that apply)*

☐ Air Travel ☐ Biking ☐ Hiking ☐ Snorkeling ☐ Swimming ☐ Rafting ☐ Boating ☐ Scuba

☐ Climbing/Trekking ☐ Contact with Animals ☐ Cave/Spelunking ☐ Public Transportation (Bus, Train)

☐ Visiting schools, hospitals or orphanages ☐ Health Care Worker ☐ Occupational Exposure

Have you obtained travel medical evacuation insurance? Y N From: _____

Health History

Heath Care Provider: _____ Telephone: _____

_____

Address: _____

_____

Do you have any chronic health problems for which you take medication on a regular basis or see a health care provider? Y N If Yes, please explain: _____

_____

_____

_____

Are you currently under the care of a physician for any health problem: Y N If Yes, please explain: _____

_____

_____

_____

Health History Continued:

Do you currently have or have a past history of:

Antidepressant or psychiatric medication use	☐ Yes	☐ No
Depression, anxiety, panic attacks	☐ Yes	☐ No
Psoriasis (skin disease)	☐ Yes	☐ No
Seizures or convulsions	☐ Yes	☐ No
Cardiac conduction defect, have a pacemaker	☐ Yes	☐ No
Heart disease or surgery	☐ Yes	☐ No
Respiratory (lung)disease	☐ Yes	☐ No
Muscle or bone problems	☐ Yes	☐ No
Intestinal problems includidng heartburn or reflux	☐ Yes	☐ No
Immune disorder (chemo, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment)	☐ Yes	☐ No
Live/work closely with anone with immune disorder	☐ Yes	☐ No
Thymus gland surgery or disorder (myasthenia gravis, DiGeorge Syndrome)	☐ Yes	☐ No
History of altitude Illness	☐ Yes	☐ No
Surgery or hospitalization in the past 3-5 years	☐ Yes	☐ No
Have you had any transfusions or blood products int he past 5 years?	☐ Yes	☐ No
Have you ever had Hepatitis (liver infection)?	☐ Yes	☐ No
Has your spleen been removed?	☐ Yes	☐ No
Do you drink alcohol regularly?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Have you ever had a TB test?	☐ Yes	☐ No
History of tendonitis/Achille's heel rupture	☐ Yes	☐ No
Other medical problems?	☐ Yes	☐ No

Please explain any YES answers: (use additional sheet if necessary) _____

_____

_____

_____

Women ONLY:

Last Menstrual period? _____ Was it normal? ☐ Yes ☐ No

Any risk of an unplanned pregnancy? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

What form of contraception do you use? _____

Allergies

Medications ☐ Yes ☐ No If Yes explain: _____

Reaction to Vaccine: ☐ Yes ☐ No If Yes explain: _____

Egg or other food allergies ☐ Yes ☐ No If Yes explain: _____

Environmental (pollen,dust, hay fever, etc.) ☐ Yes ☐ No If Yes explain: _____

Animals ☐ Yes ☐ No If Yes explain: _____

Bee Stings ☐ Yes ☐ No If Yes explain: _____

Have you ever experienced anaphylaxis (severe allergic reaction)? ☐ Yes ☐ No

Medications:

Please list **ALL** prescribed and over-the-counter medications and supplements you use or considering using for this trip:

Medication:	Reason for Use:	Medication:	Reason for Use:
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

When was your last dental visit? _____

Please tell us any additional information that you believe is important for us to know as you prepare for your current trip:

_____

_____

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature: _____ **Relationship if minor** _____

Reviewed by: _____ RN/NP/PA/MD