

**CFP Travel Clinic TRAVELER HISTORY FORM**

Complete this form and bring it to your appointment along with all immunization records.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Patient ID#: \_\_\_\_\_ Primary insurance: \_\_\_\_\_  
 Does your insurance cover:  
 Health care overseas?  Yes  No  Not sure  
 Medical evacuation?  Yes  No  Not sure  
 Birth country: \_\_\_\_\_

**TRAVEL PLANS** (list additional information on back of form if needed):

**Purpose of trip** (check all that apply)  
 Vacation  Education/research  Adoption  Visit friends or family  Missionary/volunteer/humanitarian relief  
 Work (urban, office-based, or conference)  Work (rural, outdoors, or in local community)  To obtain medical or dental care  
 Other \_\_\_\_\_

**Planned activities** (list all): \_\_\_\_\_

**Will you be:**

Visiting areas that are:  
 • Rural  Yes  No  Not sure  
 • Urban  Yes  No  Not sure  
 • Primitive or remote  Yes  No  Not sure

Ascending to high altitudes (8,000 ft or higher)?  Yes  No  Not sure  
 Working with potential exposure to body fluids (e.g., medical or dental work)?  Yes  No  Not sure  
 Working with exposure to animals?  Yes  No  Not sure  
 Potentially having new sexual partners?  Yes  No  Not sure

**Accommodations** (check all that apply):

Resort/large hotel  Small hotel/guest house/B&B  Cruise ship  Private home (with locals)  Private home (with relatives)  
 Private home (expatriate or high-end)  Primitive camping  Up-scale camp/lodge  Dormitory/ hostel  
 Other \_\_\_\_\_

**Previous international travel (year/destination):** \_\_\_\_\_  
 \_\_\_\_\_

Countries and cities in order of visit	Arrival Date	Departure Date

<b>Name</b>	<b>DOB</b>	<b>Date</b>
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**HEALTH HISTORY (Check all that apply)**
**Allergies**

- Antibiotics (e.g., penicillin, sulfa) \_\_\_\_\_
- Other medications \_\_\_\_\_
- Egg
- Latex
- Gelatin
- Yeast
- Bees/wasps
- Seasonal
- Other \_\_\_\_\_
- Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): \_\_\_\_\_

**Cancers/blood disorder**

- Coagulation disorder
- History of cancer or blood disorder
- Other \_\_\_\_\_

**Cardiovascular**

- Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- Implanted pacemaker or automatic defibrillator
- Heart attack
- High cholesterol
- High blood pressure
- Stroke
- Other \_\_\_\_\_

**Endocrine**

- Diabetes
- Thyroid disease
- Other \_\_\_\_\_

**GI**

- Crohn's disease or ulcerative colitis
- IBS
- GERD
- Chronic hepatitis
- Cirrhosis or liver failure
- Other \_\_\_\_\_

**Immune system**

- Steroids by mouth within last 3 months
- Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- Spleen removed
- Thymus disease or thymectomy
- HIV/AIDS
  - Most recent CD4: \_\_\_\_\_
  - Most recent viral load: \_\_\_\_\_
- Organ, bone marrow, stem cell transplant \_\_\_\_\_
- Other \_\_\_\_\_

**Kidneys**

- Dialysis
- Kidney insufficiency
- Other \_\_\_\_\_

**Lungs**

- Asthma
- Emphysema/COPD
- Other \_\_\_\_\_

**Musculoskeletal**

- RA
- Psoriatic arthritis
- Other \_\_\_\_\_

**Neurologic/psychiatric**

- Seizures or epilepsy
- Anxiety /depression
- History of Guillain-Barré
- Other \_\_\_\_\_

**Skin**

- Psoriasis
- Other \_\_\_\_\_

**OB/GYN**

- Pregnant: \_\_\_\_\_ weeks/trimester
- Breastfeeding
- Possible pregnancy in next 3 months
- Other \_\_\_\_\_

**VACCINATION HISTORY**  
 (Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

- |                       |  |                             |                                   |
|-----------------------|--|-----------------------------|-----------------------------------|
| Hepatitis A           | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Hepatitis B           | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Meningococcal         | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Measles/Mumps/Rubella | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Polio                 | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Tetanus               | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Typhoid               | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Yellow Fever          | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Japanese Encephalitis | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Influenza             | <input type="checkbox"/> Yes When? _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
| Other _____           |  |                             |                                   |

 Have you ever had an adverse reaction to an immunization?  No  Yes Explain: \_\_\_\_\_

Name	DOB	Date
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**CURRENT MEDICATIONS**

**Prescription medications: List all current prescription medications**

Medication	Reason for use/medical condition

**Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.**

Product	Reason for use/medical condition

**QUESTIONS/CONCERNS**

**Additional questions or concerns about your travel:**

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