DR. ERIK JONES
Family Medicine

TRAVEL MEDICAL HISTORY QUESTIONNAIRE

Name *(Last, First,M.I.):*	**Phone:**	**Date:**
Address:	**Email:**	

Country of Birth:	**Occupation:**	☐ M ☐ F	**D.O.B.**	**Age:**

Personal Physician name:	**Physician Phone:**
Physician Address:	
Have you previously traveled to a developing country? ☐ Yes ☐ No	
Are you traveling alone? ☐ Yes ☐ No	**If no, list who you are traveling with and ages:**
Departure date:	**Return date:**
Please list in order all countries you plan to visit including LAYOVERS, and the length of stay	
1.	**3.**
2.	**4.**

TRIP PURPOSE: check all that apply	**ACCOMODATIONS: check all that apply**	**TRIP ACTIVITIES: check all that apply**
☐ Business	☐ Hotel 4 or 5 Star	☐ Air travel
☐ Vacation	☐ Hotel 2 or 3 Star	☐ Public transportation e.g. bus, train
☐ Study	☐ Hostel	☐ Biking
☐ Missionary	☐ Private home	☐ Rental car
☐ Visiting friends or relatives	☐ Camping	☐ Water sports e.g. swimming, boating
☐ Safari	☐ Safari	☐ Scuba or Snorkeling
☐ Cruise	☐ Staying with locals	☐ Climbing or Hiking
☐ Long stay	☐ Long-stay apartment	☐ Visiting schools, hospitals, orphanages
☐ Volunteer or humanitarian work	☐ Cruise ship	☐ Health care worker
		☐ Contact with animals

ALLERGIES

Medication allergy ☐ Yes ☐ No Which ones?
Vaccine allergy? ☐ Yes ☐ No
Food allergy? ☐ Yes ☐ No
Environmental allergies e.g. hayfever, bee stings? ☐ Yes ☐ No
Other:

WOMEN ONLY

When was your last period?	**Are you pregnant? ☐ Yes ☐ No**	**If yes, when are you due?**
Are you at risk for pregnancy? ☐ Yes ☐ No	**What is your method of birth control?**	

NAME: **DATE:**

IMMUNIZATION HISTORY

Do you have a written record of your vaccinations? ☐ Yes ☐ No

Have you had any serious reactions to any vaccines? ☐ Yes ☐ No

Vaccines	Date(s) Received	Never had	Not sure	Had disease
Tetanus-Diphtheria Vaccine or Tdap				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series				
Polio-adult booster				
Chicken pox (Varicella) (2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (☐ oral or ☐ injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				

Other vaccines:

MEDICAL HISTORY

Psychiatric problems ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Gastrointestinal problems ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No	Heart disease or surgery ☐ Yes ☐ No	Respiratory problems ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No	Immunity problems ☐ Yes ☐ No	Immune suppression drugs ☐ Yes ☐ No

Other:

Please explain any "yes" answers:

Have you had any surgeries? ☐ Yes ☐ No **What kind?**

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the-counter, supplements and eye drops)

Name of medication	Condition or reason for use	Name of medication	Condition or reason for use
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment / administration of vaccines by the provider. I understand that payment in full by cash or credit card is due at the time of the visit. Travel Clinics of America, LLC does not bill insurance or any third party payor, including Medicare. A portion of the charges may be reimbursable by insurance.

Traveler/Parent/Guardian signature _____ **Date** _____

NAME:			DATE:
PROVIDER NOTES			
BP:	**P:**	**R:**	**TEMP:**

PRE-TRAVEL COUNSELING: check all that apply		
☐ **Food and water**	☐ **Medical care abroad**	☐ **Personal safety**
☐ **Traveler's Diarrhea self-treatment**	☐ **Personal Rx**	☐ **Accidents**
☐ **Insect protection incl. Dengue**	☐ **Altitude Illness**	☐ **STDs/HIV**
☐ **Malaria ABCD**	☐ **Water sports**	☐ **Alcohol and drug use**
☐ **Fresh water risks**	☐ **Climate risks: sun and frostbite**	
☐ **Rabies avoidance**	☐ **DVT avoidance**	☐ **FEVER in returning traveler**
☐ ***Online Video Presentation for Travelers***		
☐ ***Travel Insurance***	☐ ***Medical kit***	☐ ***Other supplies***

MEDICATIONS		
MEDICATION	**COMMON DOSING**	**RX GIVEN**
☐ **Azithromycin**	**1000 mg x 1 or 500 mg QD x 3 d for T.D.**	
☐ **Ciprofloxin**	**750 mg QD 1-3 d for T.D.**	
☐ **Rifaximin**	**200 mg QD while traveling**	
☐ **Diflucan**	**150 mg once for yeast infection**	
☐ **Chloroquine**	**500mg QW (1-2 wk before->4 wk after)**	
☐ **Doxycycline**	**100 mg QD (1-2 d before->4 wk after)**	
☐ **Malarone**	**250 mg QD (1-2 d before ->7 d after)**	
☐ **Mefloquine**	**250 mg QW (1wk before ->4 wk after)**	
☐ **Ambien**	**5-10 mg HS**	
☐ **Diamox**	**125 mg BID (1 d before -> 2 d at top)**	

NAME:				DATE:		
VACCINES	**Mfg/lot**	**Exp. Date**	**Dose/site**	**VIS Date**	**Traveler initials if recommended vaccine declined**	**Cost**
☐ Immunization Administration						
☐Each Additional Vaccine (use w/ 90471)						
☐ Consult						
HPV ☐ Gardasil ☐ Cervarix						
☐ Hepatitis A ☐ Adult ☐Peds 1st dose						
☐ " ☐ Adult ☐Peds 2nd dose						
☐ Hepatitis B ☐ Adult ☐Peds 1st dose						
☐ " ☐ Adult ☐Peds 2nd dose						
☐ " ☐ Adult ☐Peds 3rd dose						
☐ Hepatitis A + B Twinrix 1st dose						
☐ " 2nd dose						
☐ " 3rd dose						
☐ " 4th dose						
☐ Influenza						
☐ J. Enc. (Ixiaro) 1st dose						
☐ " 2nd dose						
Meningitis ☐ Menactra ☐ Menveo ☐ Menomune						
☐ MMR						
☐ Pneumococcal (PPSV)						
☐ Polio (IPV)						
☐ PPD						
Rabies: 1st dose ☐ Imovax ☐ Rabavert						
☐ " 2nd dose						
☐ " 3rd dose						
Tetanus ☐ Td ☐ Tdap ☐ DTaP						
Typhoid ☐ oral ☐ injectable						
☐ Varicella (Varivax)						
☐ Yellow Fever						
☐ Zoster (Zostavax)						

I received my VIS sheet(s) _____ (Traveler's initials)

I voluntarily and knowingly release the provider whose signature appears below, and affiliated medical facilities and staff, from any and all claims arising out of and/or relating to any provider recommended treatment and/or vaccination refused by me.

Traveler/Parent/Guardian signature _____ **Date** _____

Provider signature _____ **Nurse signature** _____