Infectious Diseases Clinic

Travel Information Form

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

House number:	City:	State:	ZIP Code:	Home phone no.: ( )
Occupation:		Employer:		Employer phone no.:
Country of birth:				( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ CDC	❑ Internet	❑ Other

Emergency Contact

Name	Phone	Cell
1. Name:	phone no.: ( )	Cell No.: ( )
2. Name:	phone no.: ( )	Cell No.: ( )

Travel History

Purpose of trip:	❑ Business	❑ Pleasure	❑ School-related study or work

Countries AND cities of the visit (chronological order) include return visits	Departure date	Arrival Date

Activities:

Question	Yes	No
Will you be visiting ONLY urban areas?	❑ Yes	❑No
Will you be staying ONLY in hotels?	❑ Yes	❑ No
Will you be exposed to and/or working with animals?	❑ Yes	❑ No
Will you be working in a health-care setting?	❑ Yes	❑ No
Will you be going to high altitudes (>6000 ft/2500m)?	❑ Yes	❑ No
Will you be potentially involved in sexual activity with any new partner or partners?	❑ Yes	❑ No
Will you be involved in aquatic activities?	❑ Yes	❑ No
Will you be involved in skilled activities?	❑ Yes	❑ No

Allergy

Have you had an allergic reaction to any of the following:

❑ Eggs	❑ Thiomerosal	❑ chrysanthemums	❑ Pyrimethamine	❑ Quinines
❑ Penicillin	❑ Sulfa	❑ Tetracycline	❑ Neomycin	❑ Cipro/Levofloxacin
❑ Azithromycin	❑ Others ________________________________			

Past Medical History		**Medications** (Prescription and non-prescription/OTC)		

Immunization History

Hepatitis A If yes, when	❑ Yes ❑No ________	**Tetanus/diphtheria** If yes, when	❑ Yes ❑No ________	**Pneumococcal** If yes, when	❑ Yes ❑No ________
Hepatitis B If yes, when	❑ Yes ❑No ________	**MMR**(measles, Mumps, Rubella) If yes, when	❑ Yes ❑No ________	**Japanese encephalitis** If yes, when	❑ Yes ❑No ________
Polio If yes, when	❑ Yes ❑No ________	**Typhoid fever** If yes, when	❑ Yes ❑No ________	**Rabies** If yes, when	❑ Yes ❑No ________
HPV If yes, when	❑ Yes ❑No ________	**Meningitis** If yes, when	❑ Yes ❑No ________	**Immune globulin** If yes, when	❑ Yes ❑No ________
Varicella If yes, when	❑ Yes ❑No ________	**Influenza (Flu)** If yes, when	❑ Yes ❑No ________	**Others** (specify) If yes, when	❑ Yes ❑No ________

For Females ONLY

When was your **last menstrual period**?	______/______/_________	
Are or could you be **pregnant**?	❑ Yes	❑No
Are you **breast feeding** an infant?	❑ Yes	❑No

_______________________________________ ______/______/__________

Signature of patient or legal guardian Date