



A Not-For-Profit Visiting Nurse Association

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INTERNATIONAL TRAVEL HEALTH PROGRAM

INTERNATIONAL TRAVEL CLINIC

Date of Scheduled Appointment: _____

Name: _____ DOB: _____ Age: ____ Gender: _____

Address: _____

Phone number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Primary Physician: _____ Phone # : _____

Country of Birth: _____ Date of Immigration to U.S.: _____

TRAVEL INFORMATION

Departure Date: _____ Return Date: _____ Total Length of Trip: _____

Number of people traveling with you: _____ OR, in your Group: _____

ITINERARY: (List Countries in Order of Travel)

<u>Country</u>	<u>City/Area</u>	<u>Country</u>	<u>City/Area</u>
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Travel Wise... Immunize Here... Be Safe There...

PURPOSE OF TRIP: (Check all that apply)

- Business Vacation Missionary Adoption
 Humanitarian Visit Family/Friends Other: _____

TYPE OF TRAVEL: (Check all that apply)

- Guided/Escorted Rural Fixed Itinerary Usual Tourist Areas
 Independent Major Cities Flexible Itinerary Unusual Tourist Areas

Check any of the following ACTIVITIES that apply to your trip:

- Provide Medical Care Ocean/Salt Water Cruise Ship Travel
 Field Work Scuba Diving/Snorkeling Caving (Spelunking)
 Animal Handling Bicycling Camping
 Tour Bus Rafting/Kayaking Trekking
 Fresh Water/Rivers/Lakes Diving/Swimming/Wading
 Sun Bathing/Exposure Altitude >10,000/ft (3040m)
 Vehicle Travel or Rental Other (please comment) _____

Check any items that you would like to discuss:

- Risk of Malaria Travelers Diarrhea
 Risk of Blood Borne Infections Motion Sickness
 Food and Water Safety Risk of Sexually Transmitted Diseases
 Recommended and required vaccines Jet Lag
 Insect-borne disease Other _____

Will your medical insurance cover illness/accidents abroad?

- Yes No Name of Insurance Carrier _____

Do you have medical evacuation insurance?

- Yes No

PERSONAL MEDICAL INFORMATION

Do you have any allergies?

Yes No

If YES, please choose from the following list:

Hay fever/Pollens Bee Stings

Shellfish Foods _____

Thimerosol Nuts

Eggs Other _____

Medications _____

Previous Vaccinations _____

Other _____

Please explain your reaction(s) to any of the above marked allergies:

Have you received gamma globulin or blood transfusions within the past year?

Yes No If yes, please explain: _____

Are you pregnant?

Yes No N/A

If yes, 1st 2nd 3rd Trimester (check one)

Is Pregnancy a possibility prior or during this trip? Yes No N/A

Are you breastfeeding? Yes No N/A

Date of last menstruation: _____

Check if you have had any of the following diseases or medical problems:

- Hepatitis A Epilepsy Insulin diabetes Heart attacks
 Hepatitis B Seizures Kidney failure/diabetes Heart Disease
 Hepatitis C Chickenpox Blood thinning meds HIV/AIDS
 Irregular heart rhythms Splenectomy
 History of thymus disease Blood thinning meds
 Problems treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis).
 Other (list below)
-
-

Date of last tuberculosis skin test: _____ ***Result:*** _____

Do you have a history of factors that may make you at risk for HIV, AIDS, or Hepatitis B? (i.e. blood transfusions, risky homosexual or heterosexual contacts, use of shared or un-sterile needles for injections of drugs or medication, tattoos, acupuncture, injections given in developing countries.)

YES NO UNKNOWN

Please list current medications:

Name of medication	Dosage	Reason for taking
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

IMMUNIZATION HISTORY:

DPT (Diphtheria,Pertussis,Tetanus)	Date of last immunization:	_____
MMR (Measles, Mumps, Rubella)	Date of last immunization:	_____
Polio/IPV/OPV	Date of last immunization:	_____
TD (Tetanus/Diphtheria)	Date of last immunization:	_____
Chickenpox (Varicella)	Date of last immunization:	_____
Hepatitis B (1-2-3)	Dates of immunizations:	_____
Hepatitis A (1-2)	Dates of immunizations:	_____
Hepatitis A & B (1-2-3)(twinrix)	Dates of immunizations:	_____
Pneumovax	Date of last immunization:	_____
Influenza	Date of last immunization:	_____
Meningococcal	Date of immunization:	_____
Rabies	Date of immunizations:	_____
Typhoid (Typhim Vi)	Date of immunization:	_____
Yellow Fever	Date of immunization:	_____
Japanese Encephalitis	Date of immunization:	_____
Typhoid oral	Date of last dose:	_____

Are you up to date on all your childhood immunizations?

Yes No

Signature of Client Requesting Travel Health Services

Date



For Travel Clinic Specialist Use Only

Recommended Travel Immunizations:

Handouts and informational material given:

Recommended prescriptions:

Referrals to PCP or other MDS/facilities:

International Certificate of Vaccination given: ___ YES ___ NO

Post-Consult visit set up? ___ Yes ___ No

Notes/Comments:

Signature of Travel Clinic Coordinator

Date