

Insert organization logo/letterhead

ID: _____
Date: _____

Travel History Form

Name: _____ DOB: _____ Sex (circle): M F
 Telephone: Home: _____ Work: _____ Mobile: _____
 Home Address: _____
 City: _____ State: _____ ZIP: _____ Email: _____
 Who is your primary care physician? _____ Telephone: _____
 ID#: _____ Primary Insurance: _____
 Does your insurance cover: Health care overseas? Yes No Not sure Medical evacuation? Yes No Not sure

Travel Plans

(list additional information on back of form if needed)

Purpose of Trip (check all that apply): Vacation Business Study Other: _____

Planned activities: _____

Will you be: Yes No

 Visiting ONLY urban areas? If no, explain: _____

 Visiting friends and/or family?

 Ascending to high altitudes (8,000 feet or higher)?

 Working with potential exposure to bodily fluids (e.g., medical or dental work)?

 Working with exposure to animals?

 Potentially having new sexual partners?

Countries and Cities in order of visit	Arrival Date	Departure Date

Accommodations: (Check all that apply.)

____ Resorts or large hotels ____ Small hotels ____ Cruise Ship ____ Private Home ____ Camp ____ Dormitory
 ____ Youth Hostel ____ Other (list) _____

Have you traveled outside the United States before? Yes No
 If yes, when and where? _____

Health History

Medical Conditions (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, psychiatric illnesses, etc) _____

Surgical History: _____

Allergies (include medications, foods (incl. eggs), environmental allergens such as ragweed): _____

Intolerances or other reactions (include side effects from previous medications, such as nausea, constipation, sleepiness, dizziness, stomach upset, etc.): _____

Vaccination History

Were you born in the United States? Yes No If no, where? _____

Have you received the following immunizations?

- Hepatitis A Yes When? _____ No Not sure
- Hepatitis B Yes When? _____ No Not sure
- Meningococcal Meningitis Yes When? _____ No Not sure
- Measles/Mumps/Rubella Yes When? _____ No Not sure
- Polio Yes When? _____ No Not sure
- Tetanus Yes When? _____ No Not sure
- Typhoid Yes When? _____ No Not sure
- Yellow Fever Yes When? _____ No Not sure
- Japanese Encephalitis Yes When? _____ No Not sure
- Influenza Yes When? _____ No Not sure
- Other: _____

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

Medications

Are you currently using corticosteroids, receiving cancer treatment, or other immunosuppressive therapy? Yes No

Prescription medications: List all current prescription medications and condition treated. (include birth control pills):

Prescription Medication	Reason for Use/Medical Condition

Nonprescription products: List all over-the-counter, herbal, homeopathic products, vitamins, supplements etc.)

Nonprescription medications	Reason for Use/Medical Condition

Women Only

Are you pregnant now, or do you suspect that you might be pregnant? Yes No

Do you have plans to become pregnant in the next 3 months Yes No

Date of your last menstrual period: _____

Questions/Concerns:

List any additional questions or concerns you have about your travel: _____

