# Pre-Travel Health Consultation and History Form

## Personal Information: Please complete this section

<table>
<thead>
<tr>
<th>Traveler's Name:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td><strong>Date of Birth</strong></td>
<td>Male [ ] Female [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
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<tbody>
<tr>
<td><strong>Telephone:</strong></td>
<td>Home _______________</td>
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<tr>
<td><strong>Email:</strong></td>
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</tbody>
</table>

| Occupation: | |
| Country of Birth: | Citizenship: |

## Trip Information:

<table>
<thead>
<tr>
<th>Date of Departure from home:</th>
<th>Return date/length of trip:</th>
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<tbody>
<tr>
<td>Have you traveled internationally in the past?</td>
<td>Yes No</td>
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<tr>
<td>Do you intend to travel frequently in the future?</td>
<td>Yes No Maybe</td>
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Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

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<tr>
<th><strong>Destination:</strong></th>
<th>Urban Rural Remote At High Altitude Beach</th>
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**Purpose of trip:** (circle all that apply)

- Vacation
- Medical care
- Business
- Education
- Adoption
- Volunteer/Humanitarian
- Visiting Friends and/or Relatives
- Long-stay traveler

**Organized tour?** Yes No Partly Explain:

<table>
<thead>
<tr>
<th><strong>Accommodations:</strong></th>
<th>Hotel Hostel Staying with locals/family/friends Rented House/Apt Camping Cruise Ship/Boat</th>
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</table>

Will you be travelling alone? Yes No If no, Explain

**Planned Activities:** (check all that apply)

- Air Travel
- Biking
- Hiking
- Swimming
- Rafting
- Boating
- Scuba
- Climbing/Trekking
- Contact with Animals
- Cave/spelunking
- Public Transport (bus, train, etc)
- Visiting schools, hospitals or orphanages
- Health Care Worker
- Occupational exposure

Other: __________________

Have you obtained travel medical evacuation insurance? Yes No

## Health History:

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<tr>
<th>Health Care Provider:</th>
<th>Telephone:</th>
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Do you have any chronic health problems you take medication for on a regular basis or see a health care provider? Yes No If yes, please explain:

Are you currently under the care of a physician for any health problem? Yes No If yes, please explain:

When was your last dental visit?

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Health History, cont’d.

Do you currently have or have a past history of:

- Antidepressant or psychiatric medication use: Yes No
- Depression, anxiety, panic attacks: Yes No
- Seizures or convulsions: Yes No
- Cardiac conduction defect, have a pacemaker: Yes No
- Heart disease or surgery: Yes No
- Respiratory (lung) disease (i.e. asthma): Yes No
- Muscle or bone problems: Yes No
- Intestinal problems including heartburn or reflux: Yes No
- Immune disorder (chemotherapy, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment): Yes No
- Live/work closely with anyone with immune disorder/undergoing chemotherapy: Yes No
- Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome): Yes No
- History of altitude illness: Yes No
- Surgery or hospitalization in past 3-5 years: Yes No
- Have you had any transfusions or blood products in the past 5 years? Yes No
- Have you ever had Hepatitis (liver infection)? Yes No
- Has your spleen been removed? Yes No
- Do you smoke? Yes No
- Other medical problem: Yes No

Please explain any “yes” answers:

Allergies:
- Medication(s): Yes No If yes, list:
  - Reaction to vaccine: Yes No If yes, list:
    - Egg or other food allergies: Yes No If yes, list:
      - (pollens, dust, hay fever, etc.): Yes No If yes, list:
    - Environmental:
      - Animals: Yes No If yes, list:
      - Bee stings: Yes No
    - Have you ever experienced anaphylaxis (severe allergic reaction)? Yes No

Medications:
Please list all prescribed and over-the-counter medications and supplements you use:

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<tr>
<th>Medication or supplement</th>
<th>Reason for use</th>
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Women:
- When was your last menstrual period? ___________ Was it normal? Yes No
- Are you currently or are you trying to become pregnant? Yes No
- Any risk of an unplanned pregnancy? Yes No
- Are you breastfeeding? Yes No
- What form of contraception do you use? ____________________________________

Attach immunization records. It may decrease the number of immunizations you need.

Do you have any additional questions about your travel?

I have answered this questionnaire fully and to the best of my ability.

Traveler’s signature ____________________________ Relationship if minor ____________ Date ____________

Reviewed by: ____________________________ RN/ NP/ PA/ MD Date: ____________________________

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