



ST. VINCENT'S
FIRST CARE
Walk-In Express Clinic

Patient Chart # _____

TRAVEL MEDICAL HISTORY QUESTIONNAIRE

Name <i>(Last, First, M.I.):</i>		Phone:		Date:	
Address:			Email:		
Country of Birth:	Occupation:	<input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.	Age:	
Personal Physician name:			Physician Phone:		
Physician Address:					
Have you previously traveled to a developing country? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you traveling alone? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Business <input type="checkbox"/> Vacation <input type="checkbox"/> Study <input type="checkbox"/> Missionary <input type="checkbox"/> Visiting friends or relatives <input type="checkbox"/> Safari <input type="checkbox"/> Cruise <input type="checkbox"/> Long stay <input type="checkbox"/> Volunteer or humanitarian work		<input type="checkbox"/> Hotel 4 or 5 Star <input type="checkbox"/> Hotel 2 or 3 Star <input type="checkbox"/> Hostel <input type="checkbox"/> Private home <input type="checkbox"/> Camping <input type="checkbox"/> Safari <input type="checkbox"/> Staying with locals <input type="checkbox"/> Long-stay apartment <input type="checkbox"/> Cruise ship		<input type="checkbox"/> Air travel <input type="checkbox"/> Public transportation e.g. bus, train <input type="checkbox"/> Biking <input type="checkbox"/> Rental car <input type="checkbox"/> Water sports e.g. swimming, boating <input type="checkbox"/> Scuba or Snorkeling <input type="checkbox"/> Climbing or Hiking <input type="checkbox"/> Visiting schools, hospitals, orphanages <input type="checkbox"/> Health care worker <input type="checkbox"/> Contact with animals	
ALLERGIES					
Medication allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Which ones?					
Vaccine allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Food allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Environmental allergies e.g. hayfever, bee stings? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other:					
WOMEN ONLY					
When was your last period?		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when are you due?	
Are you at risk for pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No			What is your method of birth control?		

NAME:		DATE:		
IMMUNIZATION HISTORY				
Do you have a written record of your vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you had any serious reactions to any vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (<input type="checkbox"/> oral or <input type="checkbox"/> injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				
Other vaccines:				
MEDICAL HISTORY				
Psychiatric problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal problems <input type="checkbox"/> Yes <input type="checkbox"/> No		
Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems <input type="checkbox"/> Yes <input type="checkbox"/> No		
Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunity problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune suppression drugs <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:				
Please explain any "yes" answers:				
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> 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			
<input type="checkbox"/> Food and water	<input type="checkbox"/> Medical care abroad	<input type="checkbox"/> Personal safety	
<input type="checkbox"/> Traveler's Diarrhea self-treatment	<input type="checkbox"/> Personal Rx	<input type="checkbox"/> Accidents	
<input type="checkbox"/> Insect protection incl. Dengue	<input type="checkbox"/> Altitude Illness	<input type="checkbox"/> STDs/HIV	
<input type="checkbox"/> Malaria ABCD	<input type="checkbox"/> Water sports	<input type="checkbox"/> Alcohol and drug use	
<input type="checkbox"/> Fresh water risks	<input type="checkbox"/> Climate risks: sun and frostbite		
<input type="checkbox"/> Rabies avoidance	<input type="checkbox"/> DVT avoidance	<input type="checkbox"/> FEVER in returning traveler	
<input type="checkbox"/> <i>Online Video Presentation for Travelers</i>			
<input type="checkbox"/> <i>Travel Insurance</i>	<input type="checkbox"/> <i>Medical kit</i>	<input type="checkbox"/> <i>Other supplies</i>	
MEDICATIONS			
MEDICATION	COMMON DOSING	RX GIVEN	
<input type="checkbox"/> Azithromycin	1000 mg x 1 or 500 mg QD x 3 d for T.D.		
<input type="checkbox"/> Ciprofloxin	750 mg QD 1-3 d for T.D.		
<input type="checkbox"/> Rifaximin	200 mg QD while traveling		
<input type="checkbox"/> Diflucan	150 mg once for yeast infection		
<input type="checkbox"/> Chloroquine	500mg QW (1-2 wk before->4 wk after)		
<input type="checkbox"/> Doxycycline	100 mg QD (1-2 d before->4 wk after)		
<input type="checkbox"/> Malarone	250 mg QD (1-2 d before ->7 d after)		
<input type="checkbox"/> Mefloquine	250 mg QW (1wk before ->4 wk after)		
<input type="checkbox"/> Ambien	5-10 mg HS		
<input type="checkbox"/> 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
<input type="checkbox"/> Immunization Administration						
<input type="checkbox"/> Each Additional Vaccine (use w/ 90471)						
<input type="checkbox"/> Consult						
HPV <input type="checkbox"/> Gardasil <input type="checkbox"/> Cervarix						
<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Adult <input type="checkbox"/> Peds 1 st dose						
<input type="checkbox"/> " <input type="checkbox"/> Adult <input type="checkbox"/> Peds 2 nd dose						
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Adult <input type="checkbox"/> Peds 1 st dose						
<input type="checkbox"/> " <input type="checkbox"/> Adult <input type="checkbox"/> Peds 2 nd dose						
<input type="checkbox"/> " <input type="checkbox"/> Adult <input type="checkbox"/> Peds 3 rd dose						
<input type="checkbox"/> Hepatitis A + B Twinrix 1 st dose						
<input type="checkbox"/> " 2 nd dose						
<input type="checkbox"/> " 3 rd dose						
<input type="checkbox"/> " 4 th dose						
<input type="checkbox"/> Influenza						
<input type="checkbox"/> J. Enc. (Ixiaro) 1 st dose						
<input type="checkbox"/> " 2 nd dose						
Meningitis <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Menomune						
<input type="checkbox"/> MMR						
<input type="checkbox"/> Pneumococcal (PPSV)						
<input type="checkbox"/> Polio (IPV)						
<input type="checkbox"/> PPD						
Rabies: 1 st dose <input type="checkbox"/> Imovax <input type="checkbox"/> Rabavert						
<input type="checkbox"/> " 2 nd dose						
<input type="checkbox"/> " 3 rd dose						
Tetanus <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> DTaP						
Typhoid <input type="checkbox"/> oral <input type="checkbox"/> injectable						
<input type="checkbox"/> Varicella (Varivax)						
<input type="checkbox"/> Yellow Fever						
<input type="checkbox"/> 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 _____			