



Travel Patient Intake Questionnaire

Please bring with you **ALL** immunization records you may have. You may have to check with previous health care providers to get all of this information.

Name: _____ Date of Birth: _____ Sex: M/F

Address: _____

Parent's/Gaurdian's Name: _____ Daytime Phone: _____

Please indicate, in the order in which the patient will visit them, the **CITIES AND COUNTRIES** to which the patient will be travelling. Also indicate the **departure date and length of stay** in each country. (bring complete itinerary to the appointment).

Is the travel to: (please circle one) URBAN/TOURIST AREAS RURAL AREA URBAN AND RURAL AREAS

What is the reason for travel: _____

Has the traveler had the following vaccinations?

Immunization	Dates given
Measles, Mumps, Rubella (MMR)	
Polio (IPV,OPV)	
Hepatitis B (Hep B)	
Hepatitis A (Hep A)	
Diphtheria, Tetnus, Pertusiss (DTap,Tdap)	
Varicella (chicken pox)	Disease?
Meningitis (Menactra or Menveo)	
H. influenza B (Hib)	
Pneumoccoal (Prevnar)	

Name: _____ Date of Birth: _____

Does the patient have any allergies to medications: _____

Circle any of the following that the patient is allergic to:

Eggs Thimerisol Gelatin Latex Bee/ Wasp Stings

Is the patient currently being treated for cancer? Yes/No

Does the patient have a deficiency of the immune system? Yes/No

Does the patient have any existing medical conditions such as diabetes, heart disease, asthma, ADD/ADHD,etc? _____

List **ALL current medications** the patient is taking, this includes prescriptions, vitamins, over the counter medications, and herbal remedies:

Has the patient been seen here before? Yes/No

Who is the patient’s primary care provider? _____

How did you hear about our travel clinic? _____

Full payment is expected at the time of service. Estimated charges will be given prior to the visit, however, the provider may change vaccinations based on medical decisions made during the visit.

Bring all immunization records to the visit.

Please fax this completed form to Center For Lifetime Health at 342-1879. If you don’t have access to a fax machine please call our office for instructions to send via e- mail.