INTERNATIONAL TRAVEL CONSULTATION FORM

Name: _____ Date: _____

Address: _____

Daytime Phone Number: _____ Cell Number: _____ Work Phone:

Date of Birth: _____ Age: ____ Weight: _____ Gender: _____M _____F

TRAVEL INFORMATION

Travel Dates - From _____ To _____

Departure Date (From U.S.) _____

Length of Stay - Weeks _____ Days _____

Travel Itinerary in order of travel (include **ALL Stopovers, even if not deplaning**) **Use back of form if needed.**

1. **Country** _____ Duration _____ Rural? _____ Urban? _____

Cities/States/Provinces Visited _____

2. **Country** _____ Duration _____ Rural? _____ Urban? _____

Cities/States/Provinces Visited _____

3. **Country** _____ Duration _____ Rural? _____ Urban? _____

Cities/States/Provinces Visited _____

4. **Country** _____ Duration _____ Rural? _____ Urban? _____

Cities/States/Provinces Visited _____

5. **Country** _____ Duration _____ Rural? _____ Urban? _____

Cities/States/Provinces Visited _____

Reason for travel (such as to provide medical care, receive medical care, construction work, pleasure, etc.)

_____

Planned activities (such as all indoor office work, outdoor recreation, etc) _____

Lodging accommodations (mark all that apply; if camping/safari, indicate in which country, if more than one country visited)

___Hotel_____Resort ____Pvt House _____Camp ____Safari ___ Other

MEDICAL INFORMATION

Medical History (attach additional information if needed):

_____

_____

_____

Previous Vaccinations and dates including childhood immunizations

Diptheria / Tetanus / Pertussis (DTaP) (DTP) 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Tetanus Diptheria (Td) (most recent only) _____

Polio (OPV) 1 _____ 2 _____ 3 _____ 4 _____

Polio (IPV) _____

HIB 1 _____ 2 _____ 3 _____ 4 _____

Prevnar 1 _____ 2 _____ 3 _____ 4 _____

Pneumococcal _____

MMR 1 _____ 2 _____

Varicella _____

Hepatitis B 1 _____ 2 _____ 3 _____

Hepatitis A 1 _____ 2 _____

Meningococcal 1 _____

Rabies 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Japanese Encephalitis 1 _____ 2 _____ 3 _____

Typhoid (oral typhoid or injectable) _____

Yellow Fever _____

Cholera _____ Other (list vaccine name/date) _____

Have you ever had an adverse reaction to any vaccine? _____Yes _____No

If yes, attach detailed explanation of reaction experienced._____

_____

_____

Current Medical Conditions: _____

_____

_____

Allergies (include food, medication, insects, etc): _____

_____

_____

Current Medications: _____

_____

_____

Do you have a HISTORY (past or present) of any of the following:

Psoriasis ____Yes _____ No **Seizure Disorder**_____ Yes ____ No **Hepatitis** ___Y __N

Heart Rhythm Problem _____ Yes ____No **Thymectomy/Thymoma/Myasthenia Gravis** ___Y ____N

Depression _____ Yes _____No **Other psychiatric illnes**_____ Yes _____ No

Are you at risk for or do you have any immune deficiency: _____Yes _____ No

Do you take any of the following medications?

Quinidine _____ Yes _____ No **Quinine** _____ Yes _____ No

Calcium Channel Blockers (Verapamil, etc.) _____ Yes _____ No

Anti-Seizure Medications _____ Yes ___No **Beta Blockers** (like Inderal, Toprol, e____Yes _____No

Female Patients Only: Are you pregnant or are you considering trying to become pregnant during your stay abroad?

_____ Yes _____ No

Client Signature: _____ Date: _____

RECOMMENDATIONS

(will be completed by PHN and Clinician)

PHN Summary:

Date_____ Signature_____ Printed Name_____

Clinician Orders:

Date_____ Signature_____ Printed Name_____