

**Traveler's Health & Immunization Center  
7900 N. Milwaukee Ave., Suite 231  
Niles, IL 60714  
(847) 663-9500  
www.travelmed.net**

**TRAVEL INFORMATION AND HEALTH HISTORY FORM**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Date of departure \_\_\_\_\_ Length of stay \_\_\_\_\_

**ITINERARY (in exact order)**

<b>DESTINATION (Country/Cities)</b>	<b>DURATION OF STAY</b>

**Nature of travel (check all that may apply):**

Business      Pleasure      Missionary      Medical      Student  
Urban      Rural      Tour Guided:    yes      no

If traveling for business: who is your employer? \_\_\_\_\_

**Activities during travel (check all that may apply):**

Trekking      Camping      Mountain climbing  
Safari      Scuba diving      Medical/dental work  
Motor vehicle use      Sunbathing      Swimming

**Accommodations (check all that may apply):**

Hotel/resort      Cruise ship      Tented camp  
Wilderness      Private home

## **MEDICAL HISTORY**

◆ Do you have or have you ever had? (check all that may apply):

- € Diabetes
- € High Blood Pressure
- € Irregular Heart Rhythm (arrhythmia)
- € Cancer (specify type, last chemotherapy and radiation treatment) \_\_\_\_\_
- € Immune Deficiency (e.g. HIV/AIDS) (specify) \_\_\_\_\_
- € Thymus gland disorder
- € Myasthenia Gravis
- € Guillain-Barre Syndrome
- € Crohn's Disease
- € Ulcerative Colitis
- € Rheumatoid Arthritis
- € Systemic Lupus
- € Tuberculosis (disease or positive skin test)
- € Eczema
- € Seizure Disorder
- € Depression or Anxiety Disorder
- € Any other mental illness for which you have received treatment
- € Reaction to a Vaccine (specify) \_\_\_\_\_
- € Travel-Related Illness (specify) \_\_\_\_\_
- € A bad reaction to a medication prescribed for malaria? (specify) \_\_\_\_\_
- € \_\_\_\_\_
- € Other (specify) \_\_\_\_\_
- € \_\_\_\_\_
- € \_\_\_\_\_

◆ Current medications: \_\_\_\_\_  
 \_\_\_\_\_

◆ Are you taking any blood thinners (e.g. coumadin)                      Yes                      No  
 If YES, which one(s)? \_\_\_\_\_

◆ Are you taking or have you taken any immunosuppressive medications?  
 (e.g. prednisone, Remicade, Enbrel)      Yes                      No  
 If YES, which one(s) and when? \_\_\_\_\_

◆ Are you **ALLERGIC** to any medications?      Yes                      No  
 If YES, which one(s)? \_\_\_\_\_

◆ Check if you are **ALLERGIC** to:      Eggs                      Yeast                      Thimerosal (mercury)

€ insect bites                      € Chicken                      € Formaldehyde                      € Neomycin

€ Gelatin                      € Latex

◆ **FOR WOMEN:**      Are you pregnant?      Yes                      No  
 Do you plan to become pregnant in the next 6 months?      Yes                      No

## IMMUNIZATION HISTORY

VACCINE	WHEN RECEIVED		
Hepatitis A			
Hepatitis B			
Twinrix (combined Hepatitis A + B)			
Yellow Fever			
Typhoid (injection)			
Typhoid (oral)			
Polio (injection)			
Polio (oral)			
Meningococcal (meningitis)			
Tetanus			
Japanese Encephalitis			
Rabies			
Varicella (Chickenpox)			
Measles			
Mumps			
Rubella (German Measles)			
Influenza (Flu)			
Pneumovax (Pneumonia)			

**I certify to the best of my knowledge all information provided on this form is complete and accurate as of today's date.**

**x** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Signature of patient/legally responsible party

Relationship to patient \_\_\_\_\_