Pre-Departure Travel Consult Form

We provide international travelers with information about the countries they are planning to visit, evaluates health care needs and risks, and suggests immunizations and medications for travel.

Please fill out this form before your appointment.

Information Regarding Travel Plans:

Date of Departure:_____/____/_____ Return Date:_____/_____/_____

Destination (City, Country)	Type of Accommodations (hotel, dorm, camping, etc.)	Length of stay:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for Travel:_____Vacation_____Student

Do you plan to visit only tourist's area or major cities? Yes No

Do you plan to visit rural areas? Yes No

Do you plan to go hiking or backpacking? Yes No

Do you plan to travel to high altitudes? Yes No

Do you plan to go swimming? Yes No
If yes: Chlorinated Pool Ocean Fresh water lake or stream

Medical History

Do you have a medical condition that warrants regular medication or physician follow-up?
Yes No
If yes, please list: _____

Do you have heart problems? Do you have a cardiac arrhythmia or irregularity? Yes No

Do you have bleeding or clotting problems; take Coumadin, anticoagulants, or aspirin? Yes No

Have you had surgery in the past three months? Yes No
If yes, describe: _____

Do you have lung disease, asthma, or shortness of breath? Yes No

Do you have any skin conditions such as psoriasis, eczema, or shingles? Yes No

Have you received any vaccinations in the past 4 weeks? Yes No
If yes, list: _____

Have you ever had a serious reaction after receiving a vaccination, such as hives, rash, wheezing, difficulty breathing, or shock? Yes No
If yes, describe reaction: _____

Do you have any dental problems? Yes No

Previous Immunizations

Please list the country of your birth: _____

Please indicate the immunizations you have received and dates:

Hepatitis A Vaccine: #1 _____ #2 _____

Hepatitis B Vaccine: #1_____ #2_____#3_____

MMR: #1_____#2_____

Polio: #1_____#2_____#3_____#4_____

Tetanus/Diptheria/Pertussis: #1_____#2_____#3_____#4_____

Tetanus Booster (Td or Tdap): _____

Hib: #1_____#2_____#3_____#4_____

Varicella: #1_____#2_____

Influenza Vaccine: _____

Meningococcal:_____

Pneumococcal:_____

Typhoid Injection: _____

Typhoid Oral Capsules: _____

Yellow Fever Vaccine: _____

Rabies Vaccine: #1_____#2_____#3_____

Japanese Encephalitis Vaccine: #1_____#2_____#3_____