MU Travel Clinic – Traveler History Form

Complete this form and bring it to the clinic appointment along with all immunization records

Name: ____ Occupation: ______________________
Age: ______________ DOB: ________________ ☐Male ☐Female
Address: _________________________________ City/State/Zip code: ____________________
Phone number: __________________ Primary care physician: _____________________________
Would you like your vaccine information forwarded to your physician? ☐Yes ☐No
Birth country: _______________

Travel plans
Purpose of trip (check all that apply)
☐Vacation ☐Education/research ☐Adoption ☐Visit friends or family
☐Missionary/volunteer/humanitarian relief ☐Work (urban, office-based, or conference)
☐Work (rural, outdoors, or in local community) ☐To obtain medical or dental care
☐Other: _____________________

Planned activities (list all):
____
____
____

Will you be:
Visiting areas that are:

- Rural ☐Yes ☐No ☐Not sure
- Urban ☐Yes ☐No ☐Not sure
- Primitive or remote ☐Yes ☐No ☐Not sure

Ascending to high altitudes (8,000 ft/2,450 m or higher)? ☐Yes ☐No ☐Not sure
Working with potential exposure to body fluids (e.g., medical or dental work)? ☐Yes ☐ No ☐Not sure
Working with exposure to animals? ☐Yes ☐ No ☐Not sure
Potentially having new sexual partners? ☐Yes ☐ No ☐Not sure

Accommodations (check all that apply):
☐Resort/large hotel ☐Small hotel/guest house/B&B ☐Cruise ship
☐ Private home (with locals) ☐Private home (with relatives) ☐Private home (expatriate or high-end)
☐Primitive camping ☐Up-scale camp/lodge ☐Dormitory/hostel
Other: ____

Previous international travel (year/destination):
____
____

This trip (including transit countries and cities):

Countries and cities in order of visit	Arrival Date	Departure Date

Health History (check all that apply)

Allergies
☐Antibiotics (e.g., penicillin, sulfa) _________
☐Other medications ______________________
☐Egg
☐Latex
☐Gelatin
☐Yeast
☐Bees/wasps
☐Seasonal
☐Other ________________________________
☐Side effects from previous medications (e.g., nausea, dizziness, stomach upset) ___________

Cancer/blood disorder
☐Coagulation disorder
☐History of cancer or blood disorder
☐Other ________________________________

Cardiovascular
☐Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
☐Implanted pacemaker or defibrillator
☐Heart attack
☐High cholesterol
☐High blood pressure
☐Stroke
☐Other ________________________________

Endocrine
☐Diabetes
☐Thyroid disease
☐Other ________________________________

Gastrointestinal
☐Crohn's disease or ulcerative colitis
☐IBS
☐GERD
☐Chronic hepatitis
☐Cirrhosis or liver failure
☐Other ________________________________

Skin
☐Psoriasis
☐Other ________________________________

Immune system
☐Steroids by mouth within last 3 months
☐Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
☐Spleen removed
☐Thymus disease or themectomy
☐HIV/AIDS
- Most recent CD4: _____
- Most recent viral load: _____

☐Organ, bone marrow, stem cell transplant
☐Other ____________________________

Kidneys
☐Dialysis
☐Kidney insufficiency
☐Other ___________________________

Lungs
☐Asthma
☐Emphysema/COPD
☐Other ___________________________

Neurologic/psychiatric
☐Seizures or epilepsy
☐Anxiety/depression
☐History of Guillain-Barre
☐Myasthenia gravis
☐Other ___________________________

Ob/Gyn
☐Pregnant: _____ weeks/trimester
☐Breastfeeding
☐Possible pregnancy in next 3 months
☐Other

Past infections
____
____
____
____
____

TB test in the past? ☐Yes ☐No

Current medications (prescription and non-prescription such as herbal supplements)

Medication	Reason for use/medical condition

Vaccination history (Please bring all vaccination records to your appointment)

Have you received the following immunizations? If yes, please indicate when.

☐Cholera
☐Hepatitis A
☐Hepatitis B
☐Haemophilus influenzae type b
☐HPV
☐Immune globulin
☐Influenza
☐Japanese Encephalitis
☐Measles/Mumps/Rubella
☐Meningococcal
☐Pneumococcal
☐Polio
☐Rabies
☐Rotavirus
☐Tick-borne encephalitis vaccine
☐Tetanus
☐Typhoid
☐Varicella
☐Yellow Fever
☐Zoster
☐BCG vaccine
☐Other

Have you ever had an adverse reaction to an immunization? ☐No ☐Yes Explain:

____

Have you received any vaccinations in the past 4 weeks? ☐No ☐Yes Explain:

____

Are you sick today? ☐No ☐Yes Explain:

____

Have you had a fever in the past 48 hours? ☐No ☐Yes

Questions or concerns about your travel?

____
____
____
____
____

How did you hear about us?

☐Employer ☐Physician ☐Friend ☐Web ☐Other