

University of Utah Medical Center
INTERNATIONAL TRAVEL CLINIC

Name: _____ DOB: _____ Age: _____
Country of Birth: _____ Date of Immigration to U.S.: _____

TRAVEL INFORMATION

Departure Date _____ Return Date _____ Total Length of Trip _____

NUMBER of people traveling with you _____ Or in your Tour Group _____

ITINERARY: (List Countries in Order of Travel)

<u>Country</u>	<u>City/Area</u>	<u>Country</u>	<u>City/Area</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

PURPOSE OF TRIP: (check all that apply)

- | | | | | |
|---|---------------------------------------|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Business/Work | <input type="checkbox"/> Vacation | <input type="checkbox"/> Missionary | <input type="checkbox"/> Adoption | <input type="checkbox"/> Visit Family/Friends |
| <input type="checkbox"/> Receive Medical Care | <input type="checkbox"/> Humanitarian | <input type="checkbox"/> Other _____ | | |

TYPE OF TRAVEL: (check all that apply)

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Guided/Escorted | <input type="checkbox"/> Rural | <input type="checkbox"/> Fixed Itinerary | <input type="checkbox"/> Usual Tourist Areas |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Major Cities | <input type="checkbox"/> Flexible Itinerary | <input type="checkbox"/> Unusual Tourist Areas |

Check any of the following ACTIVITIES that apply to your trip:

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Provide Medical Care | <input type="checkbox"/> Bicycling | <input type="checkbox"/> Rafting/Kayaking | <input type="checkbox"/> Camping |
| <input type="checkbox"/> Field Work | <input type="checkbox"/> Cruise Ship Travel | <input type="checkbox"/> Swimming/Wading | <input type="checkbox"/> Trekking |
| <input type="checkbox"/> Animal Contact/Hunting | <input type="checkbox"/> Ocean/Salt Water | <input type="checkbox"/> Sun Bathing/Exposure | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tour Bus | <input type="checkbox"/> Scuba Diving/Snorkeling | <input type="checkbox"/> Altitude > 8,000 ft (2500 m) | |
| <input type="checkbox"/> Automobile Travel | <input type="checkbox"/> Fresh Water/Rivers/Lakes | <input type="checkbox"/> Caving (Spelunking) | |

Check any items you would like to discuss:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Altitude Sickness | <input type="checkbox"/> Seeking medical care | <input type="checkbox"/> Risk of Malaria | <input type="checkbox"/> Food and Water Safety |
| <input type="checkbox"/> Insect-borne disease | <input type="checkbox"/> Traveler's diarrhea | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Jet Lag |
| <input type="checkbox"/> Risk of Blood Borne Infections | <input type="checkbox"/> Risk of Sexually Transmitted Diseases | | <input type="checkbox"/> _____ |

PERSONAL MEDICAL INFORMATION

- Yes No Did you receive your childhood vaccines?
- Yes No Have you ever had chicken pox disease or vaccine series?
- Yes No Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?
- Yes No Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last three months?
- Yes No Do you have any seizure or brain problems?
- Yes No Have you received gamma-globulin or blood transfusions with the past year?
- Yes No Have you received a TB test in the past four weeks?
- Yes No Have you ever taken anti-malarial medication? If yes, what medication: _____
Did you tolerate it well? Yes No
- Yes No Are you at-risk for blood borne infections such as: HIV, AIDS, or Hepatitis B? (Risks include: blood transfusions, unprotected homosexual or heterosexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.)
- Yes No (Females) Are you pregnant or planning on becoming pregnant? When: _____
- Yes No (Females) Are you currently breastfeeding? _____

Allergies:

Are you allergic to any of the following?

- | | | | | |
|--------------------------------|---------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Neomycin | <input type="checkbox"/> Streptomycin | <input type="checkbox"/> Polymyxin B |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Chickens | <input type="checkbox"/> Baker's Yeast | <input type="checkbox"/> Gelatin | <input type="checkbox"/> Bee Stings |
| <input type="checkbox"/> Other | Please list: _____ | | | |

PERSONAL MEDICAL INFORMATION (con't)

- Check if you have/had any of the following diseases or medical problems:** None
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Hepatitis/Liver Disorders | <input type="checkbox"/> Myesthenia gravis | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thrombophlebitis/blood clot | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Disease/Attacks |
| <input type="checkbox"/> Recurrent pneumonia | <input type="checkbox"/> Mental/emotional diseases | <input type="checkbox"/> Irregular heart rhythms | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Thymus disease/Thymectomy | <input type="checkbox"/> Blood thinning meds | |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Retinal or Visual Field Changes | |
- Conditions treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis)
- Other: _____

MEDICATION INFORMATION

(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking	Medication	Reason for Taking

IMMUNIZATION INFORMATION

Vaccine	Date of last immunization	For Office Use		Vaccine	Date of last immunization	For Office Use	
			D/D				D/D
Chickenpox* (Varicella)				MMR* (0, 1 M) (Measles/Mumps/Rubella)			
Hepatitis A [†] (0, 6 M)				PCV (Pneu. Conj.) (2, 4, 6, 12 M)			
Hepatitis B (0, 1, 6 M)				Pneumococcal			
Hepatitis A & B (Twinrix) (0, 1, 6 M) (0, 7, 21 d, 12 M)				Polio/IPV/OPV			
HIB (2, 4, 6, 12-15 M Peds)				Rabies (Pre-Ex 0, 7, 14-28 d) (Post-Ex 2 add doses req)			
HPV*				Tetanus/Diphtheria			
Influenza				Tetanus/Diphtheria/Pertussis			
Gamma Globulin				Typhoid oral [†] (0, 2, 4, 6 d)			
Japanese Encephalitis [†] (0, 7, 30 d) (0, 7, 14 d)				Typhoid injectable			
Meningococcal (Menactra)				Yellow Fever [†]			
Meningococcal (Menomune)				Zostavax*			

FOR OFFICE USE

C = Completed series	L# = Lot Number	M = Month	<u>D/D = Discussed/Declined</u>
Hx = History of disease		d = days	1 = Not covered by insurance
V1 = Visit Date: _____	Malaria proph recommended?		2 = Pt feels don't need it
V2 = Visit Date: _____	<input type="checkbox"/> Yes, _____	* Contraindicated in pregnancy	3 = Personal beliefs
V3 = Visit Date: _____	<input type="checkbox"/> No, patient at low/no risk	† Data on safety in pregnancy not available	4 = Side-effects
			5 = Get from PCP
			6 = Not enough time before travel
			7 = Will get at destination