MEMORIAL HOSPITAL OF RHODE ISLAND

TRAVEL CLINIC
TRAVEL AND HEALTH HISTORY

Name:_____ Sex (circle): M F

Address:_____ DOB:_____

_____ Age (yrs):_____

Phone:__(_____)_____

Date of departure:_____ Date of return:_____

Sequence of countries you plan to visit:_____

_____

Purpose (circle all that apply): business, vacation, family visit, missionary, social outreach, adoption.

Have you traveled to a developing country within the past ten years? YES NO

Additional Information:_____

_____

Will your trip include any of these activities:

Camping	Yes	No	Not Sure
Swimming in fresh water (excluding chlorinated hotel or resort pool)	Yes	No	Not Sure
Rafting on fresh water	Yes	No	Not Sure
Scuba diving	Yes	No	Not Sure
High altitude travel (not airplane flights)	Yes	No	Not Sure
Mountain climbing	Yes	No	Not Sure
Medical work	Yes	No	Not Sure
Farm animal contact	Yes	No	Not Sure
Wild animal contact	Yes	No	Not Sure
Overnight stay in rural area	Yes	No	Not Sure
Housing with local families	Yes	No	Not Sure

MEDICAL HISTORY:

1. List **current** medical conditions (e.g. high blood pressure, immune deficiency, diabetes, asthma, etc.):

_____

_____

2. List **past** serious medical conditions you have had, even if they are now resolved:

_____

_____

3. List any medications taken regularly (include non-prescription drugs):

_____

_____

(OVER)

4. Has your thymus gland been removed or do you have a history of problems with your thymus such as myasthenia gravis, DiGeorge syndrome or thymoma? Yes No Don't know

5. Do you have drug allergies? YES NO If yes, list medication(s) and type of reaction, such as rash: _____

Other allergies:				Type of Reaction
Eggs	Yes	No	Not Sure	_____
Iodine	Yes	No	Not Sure	_____
Thimerosal	Yes	No	Not Sure	_____
Yeast	Yes	No	Not Sure	_____
Other (pollens, dust, etc.)	Yes	No	Not Sure	_____

6. Have you had a fever in the past 48 hours? YES NO

7. Are you currently taking antibiotics or steroids? YES NO If yes, list _____

8. Have you ever fainted while having blood drawn or receiving a vaccine? YES NO

9. If you are a woman, are you pregnant or could you become pregnant during your trip? YES NO

10. Do you have any religious or cultural objections against immunization? YES NO

11. Previous immunizations (if known, fill in date received; **bring prior immunization records if possible):** (If you have questions or are unsure of your previous vaccinations, wait to discuss these with the doctor.)

Childhood Vaccines	**Travel Vaccines**
dT (Tetanus)_____	Hepatitis A_____
Polio_____	Typhoid_____
MMR (Measles, Mumps, Rubella)_____	Yellow Fever_____
Hepatitis B_____	Rabies_____
Varicella (Chickenpox)_____	JEV (Japanese Encephalitis)_____
Meningococcal _____	
HIB (Haemophilus influenzae type b)_____	

12. Have you ever had a reaction to a previously given vaccine? If yes, list vaccine and type of reaction: _____

If you have questions about completing this form, please call the Travel Clinic at (401) 729-3610.

This form was completed by:_____

Name Date

I have verified all the above information with the patient.

_____

Physician's Signature Date

s:Travel Clinic/Forms/HealthQuest, rev. 9/18/2006