

Travel Medicine Information

First Name: _____ DOB: _____

Travel Dates: When will you leave? ____ / ____ / ____ When will you return? ____ / ____ / ____

What country/countries will you be visiting?

Country: _____ Number of days/weeks: _____

Country: _____ Number of days/weeks: _____

Country: _____ Number of days/weeks: _____

What are your flight plans? _____

Reason for travel (check all that apply):

- | | | | |
|------------------------------------|---|--|---|
| ☐ Adventure | ☐ Mission work | ☐ Teaching/School | ☐ Volunteer work |
| ☐ Business | ☐ Religious trip | ☐ Vacation | ☐ Other _____ |
| ☐ Education | ☐ Research | ☐ Visiting family/friends | |

Where will you be staying? (check all that apply):

- | | | | |
|--|---|-------------------------------------|--------------------------------------|
| ☐ Cruise ship | ☐ Home/Host family | ☐ Resort | ☐ Other _____ |
| ☐ First-class hotel | ☐ Hostel | ☐ Tent/Cabin | |

What types of places will you visit? (check all that apply):

- | | | |
|--------------------------------------|------------------------------------|--------------------------------------|
| ☐ Cities | ☐ Lakes | ☐ Rivers |
| ☐ Countryside | ☐ Mountains | ☐ Towns |
| ☐ Jungle | ☐ Plains | ☐ Other _____ |

What special activities will you be doing? (circle all that apply):

- | | | |
|--|---------------------------------------|--|
| ☐ Boating | ☐ Safari | ☐ Trekking (long-distance walks,
often far from towns) |
| ☐ Camping | ☐ Scuba diving | ☐ Other _____ |
| ☐ Hiking | ☐ Swimming | |
| ☐ Mountain climbing | | |

Will you be traveling above 8000 feet (2500 meters) during your trip (other than your flight)? Yes ☐ No ☐

Past Health History: Please list illnesses and surgeries you have had: _____

- | | | |
|---|------------------------------|-----------------------------|
| Are you allergic to eggs? | ☐ Yes | ☐ No |
| Do you have a history of HIV? | ☐ Yes | ☐ No |
| Have you had disease of the Thymus gland? | ☐ Yes | ☐ No |
| Have you had a mental health condition? | ☐ Yes | ☐ No |
| Do you take prednisone regularly? | ☐ Yes | ☐ No |
| Do you have a weak immune system? | ☐ Yes | ☐ No |

Have you had cancer? ☐ Yes ☐ No

Have you had an organ transplant? ☐ Yes ☐ No

Have you had a bone marrow transplant? ☐ Yes ☐ No

Are you pregnant or could you be pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Do you take medicine that lowers your immune system like TNF or an IL-1 agent? ☐ Yes ☐ No

Do you have any allergies (medicine, food, environmental, etc.)? ☐ Yes ☐ No

List all allergies and the reaction(s) you have:

Allergy: _____ Reaction(s): _____

Allergy: _____ Reaction(s): _____

Allergy: _____ Reaction(s): _____

Allergy: _____ Reaction(s): _____

Current Medicine(s)

Medicine Name	Dose (How Much)	How Often

Vaccine History

Vaccine	Date	Vaccine	Date
Hepatitis A		Rabies	
Hepatitis B		Polio	
COVID		Shingles	
Influenza		Tetanus (Td or Tdap)	
Japanese Encephalitis		Typhoid (injection)	
MMR (measles, mumps, rubella)		Typhoid (oral)	
Meningitis		Varicella (chickenpox)	
Pneumonia		Yellow Fever	

How did you hear about us? (Check all that apply)

- ☐ A current HealthNet patient
- ☐ Another health care provider or health department
- ☐ Family or friend
- ☐ School, church, community group or other organization
- ☐ HealthNet website
- ☐ Social media
- ☐ Online search or ad
- ☐ Other _____