The International Travel Clinic
CLIENT INFORMATION

LAST NAME: ________________________ FIRST NAME: __________________ MIDDLE INITIAL: ____

BIRTH DATE: _______/______/___________ GENDER: MALE________ FEMALE______
(Month) (Day) (Year)

SOCIAL SECURITY NUMBER: ________________________

HOME ADDRESS: ____ZIP: ___________

TELEPHONE NUMBERS: Day: _______________________ Evening: __________________________

Fax: ___________________ E-Mail: ___________________________

OCCUPATION: ____

EMPLOYER: ____

EMPLOYER'S ADDRESS: ____

Who referred you to our office? ____

Primary care physician ______________________________ Telephone number __________________

Do you want us to notify your physician of this visit? Yes ____ No _____

In case of emergency, whom should we contact? _______________Telephone:_____________________

Where were you born? ____

How long have you been living in South Florida? ____

Have you traveled overseas before? Yes ___ No ___

List countries to which you traveled before:

____

____

THIS TRIP: Date of departure: ___________________
Location: Rural ____ Urban _____ Both _____

List countries of travel and length of stay in each this time:

1. _______________________________________ 2. ____________________________________

3. ____ 4. ____________________________________

5. ____

PERSONAL HISTORY

HAVE YOU EVER HAD:	YES	NO	HAVE YOU EVER HAD:	YES	NO
Scarlet Fever - Scarletina	___	___	Typhoid Fever	___	___
Chickenpox	___	___	Cholera	___	___
Pneumonia	___	___	Yellow Fever	___	___
Tuberculosis	___	___	Encephalitis	___	___
Meningitis	___	___	Anemia	___	___
Pertussis	___	___	Jaundice	___	___
Malaria	___	___	Hepatitis	___	___
Dengue Fever	___	___	Gonorrhea	___	___
Asthma	___	___	Syphilis	___	___
Hay Fever	___	___	Chlamydia	___	___
Skin Disease	___	___	Herpes	___	___
Parasites	___	___	HIV/AIDS	___	___
Motion Sickness	___	___	Ulcers	___	___
Recurrent Diarrhea	___	___	Rheumatic fever	___	___

Poisoning: Food ☐ Chemical ☐ Drug Poisoning ☐

Comments: ____

Do you have any medical condition that warrants maintenance medications or physician follow-up? Yes ___ No___
Explain: ____

Do you have a medical condition that is stable now, but that may recur while traveling) Yes ___ No ____
Explain: ____

Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer? Yes ___ No ___

Are you pregnant or might you become pregnant on this trip? Yes ___ No ___

Have you had any operations? Yes ___ No ___
Explain: ________________________________

Have you had any transfusions of blood or blood products recently? Yes ___ No ___

Have you ever been hospitalized for any illness? Yes ___ No ___
Explain: __________________________

ALLERGIES/SENSITIVITIES

Are you allergic to	YES	No		Yes	No
Eggs	___	___	Yeast	___	___
Dairy products	___	___	Soy, wheat	___	___
Beef	___	___	Fish	___	___
Gelatin	___	___	Sulfites	___	___
Mercury or thimerosal	___	___	ANY medications	___	___
Describe ________					
Penicillin	___	___	Sulfa Drugs	___	___
Mycine	___	___	Other antibiotics	___	___
Aspirin	___	___	Codeine	___	___

Tetanus	___	___	Antitoxin	___	___
Serums	___	___	Adhesive tape	___	___
Insect bites	___	___			

Any other allergies? Explain:

____

____

REVIEW OF SYSTEMS

Do you now have or have you ever had:	YES	NO		YES	NO
Eye disease	___	___	Ear disease	___	___
Eye injury	___	___	Ear injury	___	___
Impaired sight	___	___	Impaired hearing	___	___
Gastrointestinal trouble	___	___	Ulcer ☐ Indigestion ☐ Colitis ☐ Constipation ☐ Diarrhea ☐		
Change in appetite/eating habits	___	___			
Change in bowel habit	___	___			
Kidney/bladder disease	___	___	Kidney stones ☐ Infections ☐		
Liver /gall bladder disease	___	___	Jaundice ☐ Hepatitis ☐ Gall stones ☐		

Any trouble with:					
Nose	___	___	Sinuses	___	___
Mouth	___	___	Throat	___	___
Fainting spells	___	___	Seizures	___	___
Convulsions	___	___			
Dizziness	___	___	Psoriasis	___	___
Headaches	___	___	Night Sweats	___	___
Blood Pressure Problems	___	___	Palpitations	___	___
Enlarged glands	___	___	Vaginitis	___	___
Goiter or Thyroid disease	___	___	Arthritis	___	___
Emotional problems	___	___			
Cough	___	___	Frequent ☐ Chronic ☐		
Shortness of breath	___	___	On exertion ☐ at night ☐		
Spitting up blood	___	___			

Swelling of hands ☐ feet ☐ ankles ☐

Extreme tiredness ☐ weakness ☐

Comments:

____

____

____

Date of last menstrual period: ______________________

Do you take birth control pills or other hormones? Yes ___ No ____

Do you take any other medications regularly? Yes ___ No ____

What: ____

IMMUNIZATIONS

Have you had	YES	NO	DATE
Tetanus	___	___	___
Diphtheria	___	___	___
Pertussis	___	___	___
H. influenzae type B	___	___	___
Chickenpox (Varicella)	___	___	___
Hepatitis A	___	___	___
Hepatitis B	___	___	___
Measles	___	___	___
Mumps	___	___	___
Rubella	___	___	___
PPD	___	___	___
Influenza	___	___	___
Pneumococcus (pneumonia)	___	___	___
Polio	___	___	___
Rabies	___	___	___
Cholera	___	___	___
Typhoid	___	___	___
Japanese Encephalitis	___	___	___
Meningococcal	___	___	___
Plague	___	___	___
Immune Globulin	___	___	___
Yellow fever	___	___	___

Other:
____

Signature of person completing questionnaire ____

WEIGHT: _____

Physician's Notes:
____
____
____
____
____
____
____
____
____
____

Signature: _____________________________________ Date: ______________________