International Travel Clinic
6280 SW 72nd Stret Suite #607
Miami, Fl 33143
Phone: 305-668-0075 Fax: 305-668-6299
Email: intrenationaltravelclinic@gmail.com

Client Information

Last Name: _____Frist Name: _____ Middle Initial: ____

Birth Date: _____/_____/_____ Gender: Male _____ Female _____

(Month) (Day) (Year)

Home Address: _____ Zip Code: _____

Telephone Numbers: Day: _____ Evening: _____

E-Mail: _____

Occupation: _____

Employer: _____

Employer's Address: _____

Who referred you to our office? _____

Primary care physician: _____ Telephone: _____

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.

1. _____**4.** _____

1. _____**5.** _____

3._____ **6.** _____

PERSONAL HISTORY

HAVE YOU EVER HAD: YES NOHAVE YOU EVER HAD: YES NO

Altitude related illness ____ ____Sleep apnea ____ ____

Pneumonia ____ ____ Typhoid fever ____ ____

Tuberculosis	____	____	Cholera	____	____
Pertussis	____	____	Yellow fever	____	____
Malaria	____	____	Encephalitis	____	____
Dengue fever	____	____	Hepatitis	____	____
Skin disease	____	____	Gonorrhea	____	____
Parasites	____	____	Syphilis	____	____
Recurrent diarrhea	____	____	Chlamydia	____	____
Shingles	____	____	Herpes	____	____
HIV/AIDS	____	____	Rheumatic fever	____	____
Cancer	____	____	Heart disease	____	____

Poisoning: ☐ Food ☐ Chemical ☐ Drug Poisoning

Comments: _____

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 _____

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/SENSITIVITES

Are you allergic to	Yes	No	Are you allergic to	Yes	No
Eggs	___	___	Yeast	___	___
Dairy products	___	___	Soy, wheat	___	___
Gelatin	___	___	Fish	___	___
Penicillin	___	___	Sulfites	___	___
Latex	___	___	Sulfa drugs	___	___
Mycine	___	___	Codeine	___	___
Aspirin	___	___	Other antibiotics	___	___
Insect bites	___	___	Adhesive tape	___	___
Any medication (s)	___	___			

Name of medication (s) _____

Any other allergies? Explain _____

_____

_____

Current Medical Problems

Any trouble with:	Yes	No		Yes	No
Eye disease/Impaired sight	___	___	Ear disease/Impaired hearing	___	___

Gastrointestinal trouble	___	___	Ulcer	___	___
Change in appetite/eating habits	___	___	Indigestion	___	___
Kidney/bladder disease	___	___	Colitis	___	___
Liver/gall bladder disease	___	___	Constipation	___	___
Kidney stones	___	___	Diarrhea	___	___
Jaundice	___	___	Infections	___	___
Gall stones	___	___	Hepatitis	___	___
Nose/sinuses	___	___	Throat	___	___ Fainting spells
___ ___ Seizures				___	___
Convulsions	___	___	Psoriasis	___	___
Dizziness	___	___	Headaches	___	___
Blood pressure problems	___	___	Palpitations	___	___
Thyroid disease	___	___	Vaginitis	___	___
Emotional problems	___	___	Arthritis	___	___
Cough	___	___	Swelling of: ☐ Hands ☐ Feet ☐ Ankles		
Shortness of breath	___	___	Extreme: ☐ Tiredness ☐ Weakness		
Spitting up blood	___	___	Heart problems	____	___

Comments: _____

_____

_____

Date of lase menstrual period: _____

Do you take birth control pills or other hormones? Yes _____ No_____

Do you take any other medications regularly? Yes_____ No _____

What: _____

Dates of Most Recent Vaccine

Vaccines:Date:

Tetanus _____

Hepatitis A_____

Hepatitis B_____

Measles_____

Mumps_____

Rubella_____

Influenza_____

Pneumococcus (pneumonia)_____

Polio_____

Rabies_____

Cholera_____

Typhoid_____

Japanese Encephalitis_____

Shingles_____

HPV_____

Covid_____

Yellow Fever_____

Other: _____

Weight: _____

Signature of person completing questionnaire _____