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: _____

Where were you born? _____

How long have you been living in South Florida? _____

Your Trip: **Date of departure**: _____
Location: Rural: _____ **Urban:** _____ **Both:** _____

List countries of travel and length of stay in each.

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Primary reason for travel: Tourism
(circle one) Business
Volunteer/Mission
Study Abroad
Visit relatives/friends
Other _____

Symptoms: Gastrointestinal (nausea, vomiting, abdominal cramps, diarrhea)
Respiratory (cough, congestion, asthma, pneumonia)
Cutaneous (rash, insect bites, other: _____)
Systemic (fever, chills, headache, dehydration, other:_____)
Animal bite (describe: _____)

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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 _____
_____
_____

PERSONAL HISTORY

HAVE YOU EVER HAD:	YES	NO	HAVE 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	____	____

Comments: _____

Do you have any medical conditions that require regular medical follow-up? Yes__ No ___

Explain: _____

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

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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: _____

Date of last menstrual period (if applicable): _____

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 Vaccines

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 _____

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