# 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: _____