

Travel History Form

Name: _____ E-Mail address: _____

Address: _____

Date of Birth _____ Home Phone: _____ Work Phone: _____

Travel Specifics

Purpose of Trip: School related study/work Pleasure Business Other _____

What will you be doing on this trip? _____

Country	Cities	Arrival	Departure

Have you traveled outside the United States before? Yes No

If yes, where and when? _____

Have you been to WellSpan Occupational Health in the past?

Were you born in the United States? Yes No If no, where? _____

Will you be: Yes No

 Visiting ONLY urban areas? If no, explain _____

 Staying ONLY in hotels? If no, explain _____

 Visiting family and friends?

 Ascending to high altitudes (>7000 ft) in the mountains?

 Working in medical or dental field with exposure to blood or other body fluids?

 Working with exposure to animals?

RECOMMENDED VACCINATIONS/MEDICATIONS

(to be completed by provider)

Vaccinations:

Hepatitis A

Hepatitis B

Twinrix

Polio

T-dap (one adult dose only)

Tetanus/Diphtheria

MMR

Typhoid Fever (every 2 years)

Yellow Fever (every 10 years)

Japanese Encephalitis (every 2 years)

Rabies

Menomune (every 5 years)

Menactra (as indicated)

Influenza

Malaria:

Malarone

Mefloquine

Chloroquine

Doxycycline

Travelers diarrhea:

Cipro

Azithromycin

Altitude sickness:

Diamox

Have you ever had an allergic reaction to any of the following? (Please check all that apply)

Eggs
Sulfa drugs (Bactrim, Septra)
Neomycin, Streptomycin
Gelatin

Quinines (Chloroquine, Mefloquine)
Thimerosal (preservative)
Tetracycline's
Yeast
Other _____

Immunizations

Check which immunizations you have started or completed:

Date(s)

Hepatitis A	_____
Hepatitis B	_____
Meningococcal meningitis	_____
MMR (measles/mumps/rubella)	_____
Polio	_____
Diphtheria/Tetanus	_____
Yellow Fever	_____
Typhoid Fever	_____
Japanese Encephalitis	_____

Health History

List any past or current medical problems _____

Are you using steroids, receiving radiation therapy or other immunosuppressive chemotherapy? yes no

Please list all medications you are currently taking, including over the counter and birth control pills:

1.	4.	7.
2.	5.	8.
3.	6.	9.

For women only: Should avoid getting pregnant for 4 weeks after getting MMR vaccine.

Yes No Are you currently pregnant?
Yes No Are you currently breastfeeding?

Questions/Concerns

Please list additional questions or concerns that you might have regarding your travel: