COURTYARD PHARMACY
ADVICE • CARE • TRUST

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Travel History Form

Name:_____ DOB:_____ Marital Status:_____ Sex (circle): M F

Telephone: Home: _____ Work:_____ Mobile:_____

Home Address: _____

City: _____ State:_____ Zip: _____ E-mail: _____

Who is your primary care physician? _____ Tel: _____

Employer: _____ Primary Insurance: _____

Does your insurance cover: Health care overseas? ☐ Yes ☐ No ☐ Not Sure Medical evacuation? ☐ Yes ☐ No ☐ Not Sure

Travel Plans

Purpose of trip (check all that apply): ☐ Vacation ☐ Business ☐ Study ☐ Other: _____

Planned Activities: _____

Will you be: Yes	No	
☐	☐	Visiting ONLY urban areas? If no, explain: _____
☐	☐	Visiting friends and/or family?
☐	☐	Ascending to high altitudes?
☐	☐	Working with potential exposure to bodily fluids (e.g., medical or dental work)?
☐	☐	Working with exposure to animals?
☐	☐	Potentially having new sexual partners?

Countries and Cities (in order of visits)	Arrival Date	Departure Date

List additional information on back of form

Accommodations (check all that apply):

☐ Resorts or Large Hotels ☐ Small Hotels ☐ Cruise Ship ☐ Private Home ☐ Camp ☐ Dormitory

☐ Youth Hostel ☐ Other (specify) _____

Have you traveled outside of the United States before? ☐ Yes ☐ No

If yes, when and where? _____

Health History

Medical Conditions (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, and psychiatric illnesses: _____

_____

Surgical History: _____

_____

Allergies (include medications, food such as eggs, environmental allergens such as ragweed): _____

_____

Intolerances or other reactions (include side effects from previous medications, such as nausea, constipation, sleepiness, dizziness, stomach upset, etc.):

_____

_____

Vaccination History

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

Have you received the following immunizations?

Hepatitis A	☐ Yes	When?	☐ No	☐ Not Sure
Hepatitis B	☐ Yes	When?	☐ No	☐ Not Sure
HPV	☐ Yes	When?	☐ No	☐ Not Sure
Influenza	☐ Yes	When?	☐ No	☐ Not Sure
Japanese Encephalitis	☐ Yes	When?	☐ No	☐ Not Sure
Meningococcal Meningitis	☐ Yes	When?	☐ No	☐ Not Sure
Measles/ Mumps/ Rubella	☐ Yes	When?	☐ No	☐ Not Sure
Pneumococcal	☐ Yes	When?	☐ No	☐ Not Sure
Polio	☐ Yes	When?	☐ No	☐ Not Sure
Tetanus	☐ Yes	When?	☐ No	☐ Not Sure
Typhoid	☐ Yes	When?	☐ No	☐ Not Sure
Varicella	☐ Yes	When?	☐ No	☐ Not Sure
Yellow Fever	☐ Yes	When?	☐ No	☐ Not Sure
Zoster (shingles)	☐ Yes	When?	☐ No	☐ Not Sure

Other: _____

Have you ever had an adverse reaction to an immunization? ☐ Yes Explain: _____ ☐ No

Medications

Are you currently using corticosteroids, receiving cancer treatment, or other immunosuppressive therapy? ☐ Yes ☐ No

Prescription Medications: List all current prescription medications and condition treated (include birth control pills):

Prescription Medications	**Reason for Use/Medical Condition**

Nonprescription Products: List all over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.)

Medications	**Reason for Use/Medical Condition**

Women Only

Are you pregnant now, or do you suspect that you might be pregnant? ☐Yes ☐No Date of last Period: _____

Do you have plans to become pregnant in the next 6 months? ☐Yes ☐No

Questions/Concerns:

List any additional questions or concerns you have about your travel: _____

_____