PrescribeWellness Center | CHAPMAN UNIVERSITY School of Pharmacy

TRAVEL MEDICAL HISTORY QUESTIONNAIRE

Name *(Last, First,M.I.):*	**Phone:**	**Date:**
Address:	**Email:**	

Country of Birth:	**Occupation:**	☐ **M** ☐ **F**	**D.O.B.**	**Age:**

Personal Physician name:	**Physician Phone:**
Physician Address:	

Have you previously traveled to a developing country? ☐ **Yes** ☐ **No**

Are you traveling alone? ☐ **Yes** ☐ **No**	**If no, list who you are traveling with and ages:**
Departure date:	**Return date:**

Please list in order all countries you plan to visit including LAYOVERS, and the length of stay

1.	**3.**
2.	**4.**

TRIP PURPOSE: check all that apply	**ACCOMODATIONS: check all that apply**	**TRIP ACTIVITIES: check all that apply**
☐ **Business**	☐ **Hotel 4 or 5 Star**	☐ **Air travel**
☐ **Vacation**	☐ **Hotel 2 or 3 Star**	☐ **Public transportation e.g. bus, train**
☐ **Study**	☐ **Hostel**	☐ **Biking**
☐ **Missionary**	☐ **Private home**	☐ **Rental car**
☐ **Visiting friends or relatives**	☐ **Camping**	☐ **Water sports e.g. swimming, boating**
☐ **Safari**	☐ **Safari**	☐ **Scuba or Snorkeling**
☐ **Cruise**	☐ **Staying with locals**	☐ **Climbing or Hiking**
☐ **Long stay**	☐ **Long-stay apartment**	☐ **Visiting schools, hospitals, orphanages**
☐ **Volunteer or humanitarian work**	☐ **Cruise ship**	☐ **Health care worker**
		☐ **Contact with animals**

ALLERGIES

Medication allergy ☐ **Yes** ☐ **No** **Which ones?**

Vaccine allergy? ☐ **Yes** ☐ **No**

Food allergy? ☐ **Yes** ☐ **No**

Environmental allergies e.g. hayfever, bee stings? ☐ **Yes** ☐ **No**

Other:

WOMEN ONLY

When was your last period?	**Are you pregnant?** ☐ **Yes** ☐ **No**	**If yes, when are you due?**
Are you at risk for pregnancy? ☐ **Yes** ☐ **No**	**What is your method of birth control?**	

NAME: **DATE:**

IMMUNIZATION HISTORY

Do you have a written record of your vaccinations? ☐ Yes ☐ No

Have you had any serious reactions to any vaccines? ☐ Yes ☐ No

Vaccines	Date(s) Received	Never had	Not sure	Had disease
Tetanus-Diphtheria Vaccine or Tdap				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series				
Polio-adult booster				
Chicken pox (Varicella) (2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (☐ oral or ☐ injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				

Other vaccines:

MEDICAL HISTORY

Psychiatric problems ☐ Yes ☐ No	**Seizures** ☐ Yes ☐ No	**Gastrointestinal problems** ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No	**Heart disease or surgery** ☐ Yes ☐ No	**Respiratory problems** ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No	**Immunity problems** ☐ Yes ☐ No	**Immune suppression drugs** ☐ Yes ☐ No

Other:

Please explain any "yes" answers:

Have you had any surgeries? ☐ Yes ☐ No **What kind?**

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the-counter, supplements and eye drops)

Name of medication	Condition or reason for use	Name of medication	Condition or reason for use
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment / administration of vaccines by the provider. I understand that payment in full by cash or credit card is due at the time of the visit. TravelCare International, LLC does not bill insurance or any third party payor, including Medicare. A portion of the charges may be reimbursable by insurance.

Traveler/Parent/Guardian signature _____ **Date** _____