

## Hendricks Pharmacy International Travel Health Clinic

\*\*\*Please complete all of the following information and then either email, fax, or mail these forms back to Hendricks Pharmacy in order to schedule your appointment\*\*\*

### Cancellation fee: \$30

A \$30 fee will be charged for cancellation or rescheduling of any appointment with less than 24 hours notice.

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Physician name: \_\_\_\_\_

Physician phone/fax number: \_\_\_\_\_

Returning patient to travel health clinic? (yes/no): \_\_\_\_\_

Purpose of current travel (e.g. business, pleasure, service): \_\_\_\_\_

Briefly describe your travel plans/activities: \_\_\_\_\_

Are you covered by a health insurance plan while overseas? \_\_\_\_\_

**Please fill in your travel itinerary, including all dates of arrival and departure**

Destination (Please List Specific City and Country)	Arrival	Departure

**Will you be**

Visiting ONLY urban areas? If no, please explain \_\_\_\_\_

**Yes    No**

  

Staying ONLY in hotels? If no, please explain \_\_\_\_\_

  

Traveling to high altitudes (> 10,000 ft. or 2,000 m)?

  

Handling blood/blood products or working in a hospital or clinic?

  

Engaging in sexual activities with a new partner?

  

Visiting either family or friends?

  

Working with exposure to animals?

**Allergies**

1. No known drug allergies  No known food allergies

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

- |                                                        |                                                                         |
|--------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Eggs                          | <input type="checkbox"/> Anti-malarials (i.e. Aralen, Larium, Malarone) |
| <input type="checkbox"/> Sulfa drugs (bactrim, spetra) | <input type="checkbox"/> Tetracyclines (minocin, doxycycline)           |
| <input type="checkbox"/> Antibiotics (i.e. neomycin)   | <input type="checkbox"/> Gelatin                                        |
| <input type="checkbox"/> Chrysanthemums                | <input type="checkbox"/> Other: _____                                   |

**Vaccination History:**

	Yes	No	Date(s) of administration
1. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Dose 1: _____ Dose 2: _____
2. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Dose 1: _____ Dose 2: _____ Dose 3: _____
3. Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Typhoid (oral, injectable)	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. MMR	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Yellow fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Immune globulin	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Other (please list): _____			_____

Are you currently being treated for cancer or other immunosuppressive conditions? Y/N/Not Sure  
 Are you currently receiving chemotherapy or other immunosuppressive medications? Y/N/Not Sure

**C. Medical and Medication History (list all current medical conditions and medications)**

Medical condition	Medication(s) used for condition

**D. Do you or other family members have any of the following medical conditions?**

Yes	No	Family History	Yes	No	Family History	Yes	No	Family History
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> G6PD deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lung disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Prostate disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psoriasis/Skin disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sickle cell disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Immune system disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other

If female, are you currently pregnant or planning on becoming pregnant? \_\_\_\_\_

If female, are you currently breast-feeding an infant? \_\_\_\_\_

What concerns relating to your travel do you have? \_\_\_\_\_

\_\_\_\_\_