

Hendricks Pharmacy International Travel Health Clinic

137 Harvard Ave. Claremont, CA 91711

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Email: travel@hendrickspharmacy.com

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. Cancellation will also result if late more than 10 minutes to scheduled appointment.

Today's date: _____

Name: _____

Date of birth: _____

Address: _____

City, State, Zip: _____

Phone number(s): _____

Physician name: _____

Physician phone/fax number: _____

Physician mailing address: _____

Purpose of 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 (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, Lariam, 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? _____
