TRAVEL HISTORY FORM

Date: ____

Name:____ Date of Birth:____

Address: ____

Street *City* *State* *Zip Code*

Home Phone: _____________________________________ Work Phone: ______________________________________

E-Mail:________________________ _____________________ Marital Status: ________ Race:______ Sex: M___F___

List allergies to any medication, vaccine, or food:_______________ ____

Do you have any medical problems that warrant medications or physician follow up? Yes__________ No____________

If yes, what:____ _______________

Medications currently taking:____

____

Do you now or have you ever had: Heart abnormality Yes_____ No_____ Seizure or Epilepsy Yes_____ No______

Psychiatric disorder/anxiety/history of depression: Yes_____ No_____ If yes, please describe: _____________________

Psoriasis Yes_______ No_______ Are you now or might you become pregnant on your trip? Yes _______ No_________

I wish to be counseled alone _________________with spouse _______________with other_____________(please initial)

TRAVEL ITINERARY

Cruise Ship Yes_________ No__________ If yes, name of ship____

PURPOSE OF TRIP

Leisure__________ Missionary_________ Business__________ Urban_________ Rural_______ Other_____________

PLEASE LIST, IN ORDER, THE PLACES/COUNTRIES WHERE YOU WILL BE TRAVELING. INCLUDE DATES OF DEPARTURE AND ARRIVAL.

____
____
____
____

Have you ever had a positive PPD (tuberculin skin test or the BCG vaccine)? Yes ______________ No______________

Are you a frequent traveler? Yes ____ No____ Comments ____

How did you hear about us?____ __________________________________

____ ____

Parent/Guardian/Client Signature **Date**