



Houston County Health Department Travel Clinic  
Travel History

Client # \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
*City State Zip Code*

Home Phone: ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

SSN: \_\_\_\_\_ 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? Y \_\_\_ N \_\_\_

If Yes, what: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_  
\_\_\_\_\_

Do you now or have ever had:

Heart abnormality Y \_\_\_ N \_\_\_ Seizure or Epilepsy Y \_\_\_ N \_\_\_ Psoriasis Y \_\_\_ N \_\_\_

Psychiatric Disorder/anxiety/history of depression Y \_\_\_ N \_\_\_ If yes, please describe:  
\_\_\_\_\_

Are you now or might you become pregnant on your trip? Y \_\_\_ N \_\_\_

I wish to be consulted alone \_\_\_\_\_ with spouse \_\_\_\_\_ with other \_\_\_\_\_ (please Initial)

Travel Itinerary

Cruise Ship Y \_\_\_ N \_\_\_ 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? Y \_\_\_ N \_\_\_

Are you a frequent traveler? Y \_\_\_ N \_\_\_ Comments \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Client Signature: \_\_\_\_\_