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: _____

Rev. dkl 4/08