Macon-Bibb County Health Department Travel Clinic

Travel History

Client # _____ **Date _____**

Name: _____ Date of Birth: _____

Address: _____

City ***State*** ***Zip Code***

Home Phone: ( ) _____ Work ( ) _____

Marital Status _____ Race _____ Sex: M ___ F ___ Nationality_____

List allergies to any medication, vaccine or food: _____

Do you take allergy shots?_____ If so, when was the last one?_____

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: _____

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