Document Type: Forms/Other

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METHODIST PHYSICIANS CLINIC

Methodist Travel Clinic Questionnaire

Please fax completed form back to

(402) 354-1535

Today's Date: _____ / _____ / _____ (MM/DD/Year)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Gender □ Male □ Female

Home Phone #: (_____) _____ Work Phone #: (_____) _____

Cell Phone #: (_____) _____ E-mail Address: _____

Emergency Contact: _____ Contact's Phone Number: (_____) _____

Primary Care Physician: _____ Physician's Phone Number: (_____) _____

Do you have a current passport or visa? □ Yes a passport □ Yes, a visa □ No □ Don't Know

Travel Specifics:

1. Purpose of Trip: □ School Related Study/Work School/Company's Name: _____
   □ Pleasure □ Business □ Mission Trip □ Other: _____
2. What will you be doing on this trip? _____
3. Does your program require completion of a medical form by a practitioner? □ Yes □ No
4. Are you currently enrolled in a health insurance plan that covers you while you are over seas?
   □ Unsure □ No □ Yes If yes, what insurance plan do you have? _____
5. Departure Date from the United States: _____ 6. Return Date to the United States: _____

Countries **AND** Cities to Be Visited **In Order** of Visits	Locale (city, rural, jungle, mountain)	Arrival Date (mm/dd/year)	Departure Date (mm/dd/year)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

7. Have you traveled outside of the United States before? □ Yes □ No
   If yes, where and when? _____
8. Will you be:

Yes	No	
□	□	Visiting only urban areas? If no, explain: _____
□	□	Staying only in hotels? If no, explain: _____
□	□	Visiting friends and family?
□	□	Ascending to high altitudes (>7,000 feet or 2,300 meters) in the mountains?
□	□	Working in a medical or dental field with exposure to blood/other body fluids?
□	□	Working with exposure to animals?
□	□	Potentially having sexual contact with new partners?

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

NMHS-418
Rev. 4/2024

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Immunizations:

1. Were you born in the United States? □ Yes □ No If no, where: _____
2. Have you completed the following immunizations?

Hepatitis A	□ Not Sure	□ No	□ Yes	If yes, when: _____
Hepatitis B	□ Not Sure	□ No	□ Yes	If yes, when: _____
Influenza (current year)	□ Not Sure	□ No	□ Yes	If yes, when: _____
Japanese Encephalitis	□ Not Sure	□ No	□ Yes	If yes, when: _____
Meningococcal Meningitis	□ Not Sure	□ No	□ Yes	If yes, when: _____
MMR (Measles, Mumps, Rubella)	□ Not Sure	□ No	□ Yes	If yes, when: _____
Polio Series	□ Not Sure	□ No	□ Yes	If yes, when: _____
Rabies Series	□ Not Sure	□ No	□ Yes	If yes, when: _____
Tetanus	□ Not Sure	□ No	□ Yes	If yes, when: _____
Typhoid	□ Not Sure	□ No	□ Yes	If yes, when: _____
Yellow Fever	□ Not Sure	□ No	□ Yes	If yes, when: _____
Other	□ Not Sure	□ No	□ Yes	If yes, when: _____

Medical History:

1. Are you taking steroids, receiving radiation therapy, or other immunosuppressive chemotherapy

□ Yes □ No If yes, what: _____

2. Please list your current prescription medications and medical conditions being treated (include birth control pills)

Current Prescription Medications	Condition or Reason for Use

3. Please list regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc)

Regularly Used Non-Prescription Medications	Condition or Reason for Use

4. Have you been told you have any of the following medical conditions (check all that apply)?

	Yes	No	Family History		Yes	No	Family History		Yes	No	Family History
Stomach Ulcers	□	□	□	Epilepsy/Seizure Disorder	□	□	□	Cancer	□	□	□
Kidney Disease	□	□	□	Ear Infections (chronic/frequent)	□	□	□	Stroke	□	□	□
G6PD Deficiency	□	□	□	High Blood Pressure	□	□	□	Diabetes	□	□	□
Sickle Cell Disease	□	□	□	Immune System Deficiency	□	□	□	Eye Problems	□	□	□
Hearing Problem	□	□	□	Liver Disease/Hepatitis	□	□	□	Gout	□	□	□
Lung Disease	□	□	□	Prostate Problems	□	□	□	Anemia	□	□	□
High Cholesterol	□	□	□	Psoriasis/Other Skin Problems	□	□	□	Depression	□	□	□
Thyroid Problems	□	□	□	Psychiatric Problems	□	□	□	Heart Disease	□	□	□
Hormone Problems	□	□	□	Blood Clotting Problems	□	□	□	Asthma	□	□	□

Other: _____

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

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Allergies:

1. Have you had a reaction to any of the following? (please check all that apply)

□ Eggs □ Sulfa Drugs (e.g., Bactrim, Septra) □ Chrysanthemums

□ Pyrimethamine □ Antibiotics (e.g., Neomycin, Streptomycin) □ Thimerosal (preservative in contact lens solution

□ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], or Primaquine)

□ Tetracyclines (doxycycline, Minocin, Minocycline, Acromycin, Sumycin) □ Other: Please specify _____

2. Do you have any food or drug allergies not listed above? If so, please list: _____

For Women Only:

a. When was your last menstrual period? _____

b. Are you, or could you possibly be, pregnant? □ Yes □ No

c. Are you breast-feeding an infant? □ Yes □ No

Questions or Concerns: Please list additional questions or concerns that you might have regarding your travel. (i.e. dealing with motion sickness, altitude sickness, etc.) _____

How did you hear about us?

□ Pharmacy_____ □ Word of Mouth, if so who: _____

□ Internet, if so what website _____ □ Marketing Materials: _____

□ Referral from your physician - Dr: _____ □ Other, please explain: _____

By signing below, I acknowledge that the information contained in this document is accurate and complete to the best of my knowledge. If medications will be prescribed to me, I understand that the clinic is operating under a drug therapy management protocol with the medical director, and I consent to be treated following this protocol.

X _____ _____

Signature Date

BELOW THIS LINE IS FOR OFFICE USE ONLY:

Date and time of appointment _____ / _____ / _____ at _____ □ am □ pm

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD