



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
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Patient Label
NAME: _____ DOB: _____
FIN: _____ MRN: _____

PERMANENT PART OF MEDICAL RECORD



Immunizations:

1. Were you born in the United States? Yes No If no, where: _____
2. Have you completed the following immunizations?
- | | | | | |
|-------------------------------------|-----------------------------------|-----------------------------|------------------------------|---------------------|
| Hepatitis A..... | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Hepatitis B | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Influenza (current year) | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Japanese Encephalitis..... | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Meningococcal Meningitis | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Polio Series | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Rabies Series | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Tetanus | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Typhoid | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Yellow Fever | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, when: _____ |
| Other..... | <input type="checkbox"/> Not Sure | <input type="checkbox"/> No | <input type="checkbox"/> 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)?

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

Other: _____

Patient Label

NAME: _____ DOB: _____

FIN: _____ MRN: _____

PERMANENT PART OF MEDICAL RECORD



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