Bluegrass Travel Clinic

1720 Nicholasville Rd. Ste 602 Lexington, KY 40503
Phone: 859-277-4005 Fax: 859-278-2507

TRAVELER HISTORY FORM

Complete this form and bring it to the clinic appointment along with all immunization records.

Name: _____ DOB: _____ Gender: _____

Home Phone: _____ Mobile Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Birth country: _____

Email: _____

Emergency Contact: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Primary care physician: _____ Phone: _____

TRAVEL PLANS:

Purpose of trip (check all that apply)
☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends or family ☐ Missionary/volunteer/humanitarian relief
☐ Work (urban, office-based, or conference) ☐ Work (rural, outdoors, or in local community) ☐ To obtain medical or dental care
☐ Other _____

Planned activities (list all): _____

Will you be*:*
Visiting areas that are:

- Rural ☐ Yes ☐ No ☐ Not sure
- Urban ☐ Yes ☐ No ☐ Not sure
- Primitive or remote ☐ Yes ☐ No ☐ Not sure

Ascending to high altitudes (8,000 ft or higher)? ☐ Yes ☐ No ☐ Not sure

Working with potential exposure to body fluids (e.g., medical or dental work)? ☐ Yes ☐ No ☐ Not sure

Working with exposure to animals? ☐ Yes ☐ No ☐ Not sure

Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

Accommodations (check all that apply):

☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise ship ☐ Private home (with locals) ☐ Private home (with relatives)

☐ Private home (expatriate or high-end) ☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/ hostel

☐ Other _____

Previous international travel (year/destination): _____

_____

Countries and cities in order of planned visit	Arrival Date	Departure Date

Provider reviewed: ☐

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Name	DOB	Date

HEALTH HISTORY (Check all that apply)

Allergies
- ☐ Antibiotics (e.g., penicillin, sulfa) _____
- ☐ Other medications _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other _____
- ☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): _____

Cancers/blood disorder
- ☐ Coagulation disorder
- ☐ History of cancer or blood disorder
- ☐ Other _____

Cardiovascular
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other _____

GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other _____

Immune system
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - Most recent CD4: _____
  - Most recent viral load: _____
- ☐ Organ, bone marrow, stem cell transplant _____
- ☐ Other _____

Kidneys
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other _____

Musculoskeletal
- ☐ RA
- ☐ Psoriatic arthritis
- ☐ Other _____

Neurologic/psychiatric
- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Myasthenia gravis
- ☐ Other _____

Skin
- ☐ Psoriasis
- ☐ Other _____

OB/GYN
- ☐ Pregnant: _____ weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other _____

VACCINATION HISTORY
(Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

Hepatitis A	❑ Yes When? _____	❑ No	❑ Not sure
Hepatitis B	❑ Yes When? _____	❑ No	❑ Not sure
Meningococcal	❑ Yes When? _____	❑ No	❑ Not sure
Measles/Mumps/Rubella	❑ Yes When? _____	❑ No	❑ Not sure
Polio	❑ Yes When? _____	❑ No	❑ Not sure
Tetanus	❑ Yes When? _____	❑ No	❑ Not sure
Typhoid	❑ Yes When? _____	❑ No	❑ Not sure
Yellow Fever	❑ Yes When? _____	❑ No	❑ Not sure
Japanese Encephalitis	❑ Yes When? _____	❑ No	❑ Not sure
Influenza	❑ Yes When? _____	❑ No	❑ Not sure

Other _____

Have you ever had an adverse reaction to an immunization? ❑ No ❑ Yes Explain: _____

_____

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CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:

_____

_____

_____

_____

Consent for Treatment

I, hereby, give my permission for Drs. Banks, Meek, Dougherty, Piercy, Rose, Rodrigue, Miedler, Allen, and/or Alexander to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to my treatment being rendered. I will be given the opportunity to ask questions and have them answered to my satisfaction. It is my responsibility to ask for clarification of any aspects of my treatment that are unclear. I understand that I may decline recommended treatment(s) at any time, but that if I choose to do so, it is at my own medical risk.

Signed:_____ Date:_____
(or Parent/Guardian)

Provider reviewed: ☐