



Pre-Travel Consultation Form

PATIENT INFORMATION

_____ Date

 Name (Last, first, middle initial) Patient ID #

 Street address City State ZIP Code

 Primary phone number Other phone number E-mail address

SPECIFIC TRAVEL INFORMATION

Destinations – Please list your destinations IN THE ORDER of when you are traveling to them.

Destination (City/Town, Country)	Duration of Stay	Rural or Urban?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Purpose of Travel

- Adventure Business Visiting Family or Friends
 Leisure Aid Work/Mission Other _____

Style of Travel

- Backpacking Resort Camping
 Other _____

Types of Accommodation

- Hotels Hostels Home of Family/Friends
 Camping (tents) Vacation home Other _____

Activities

Please list activities you have planned (or think you may do) during your trip. (For example: scuba diving, high altitude hiking, etc.)

PERSONAL INFORMATION

Were you born in the U.S.?

- Yes No, then where were you born? _____

Health Conditions

Please list any health conditions or issues you have.

Medications

Please list all current medications.

Allergies

Please list all allergies. (Especially allergies to eggs)

Previous Vaccination History

Please vaccinations, immunizations, or medications you have already had. Your yellow immunization card or your primary care physician can provide you with this information. Please also indicate if you had any reaction to the vaccinations listed.

Final Note

Please fill this out and mail it or fax it to us before your appointment. When you come in for your appointment your physician will have reviewed this and will be prepared to give you the up-to-date, personalized information you will need to have a safe and healthy trip.

At the time of your appointment, please remember to bring a copy of your **itinerary** and your **yellow immunization card** (if you do not already have one or do not know how to access yours we can provide you with one.)