
Traveler Intake Form

Name: _____ Age: _____ DOB: _____
Today's Date: _____
Date of Departure: _____
Date of Return: _____
Destination: _____

Reason for Travel Business Pleasure Field Work
 Medical Mission Other _____

Itinerary Cities Small Towns Rural
 Private Homes Western-style Hotels
 Camping Trekking High Altitude
 Other _____

Check medical conditions that you have:

- | | |
|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> DiGeorge Syndrome | <input type="checkbox"/> Pregnancy, <u>ANY POSSIBILITY</u> |
| <input type="checkbox"/> Guillaine-Barre Syndrome | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Rhythm Disorder | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stomach or Duodenal Ulcers |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thymoma or Thymectomy |

Other Medical Problems? No Yes (If yes, please list in space below)

Name: _____

Are you taking Medications? No Yes (If yes, please list in space below)

Medicine Allergy? No Yes, Drug: _____

Allergy to chicken or eggs? No Yes

Previous reaction to vaccines? No Yes

Do you feel well today? No Yes

Vaccination History

- | | | |
|------------------------------|---------------------------------------|--|
| Tetanus/diphtheria | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Tet/diphth/pertusis (Adacel) | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Polio | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Measles (MMR) | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Influenza | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Pneumovax | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Hepatitis A | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Hepatitis B | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Yellow Fever | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Typhoid injectable | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Typhoid oral | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Meningococcal | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Meningococcal (Menactra) | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Rabies | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Japanese Encephalitis | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Chickenpox | <input type="checkbox"/> Never/Unsure | <input type="checkbox"/> Yes: date _____ |
| Other | _____ | |

Intake form reviewed by: Cameron Cover, MD Jennifer Marfori, MD Rachel Plotinsky, MD

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