

**CABARRUS HEALTH ALLIANCE**  
**International Travel**

**TRAVEL AND HEALTH HISTORY**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_

**TRAVEL INFORMATION**

Date of Departure \_\_\_\_\_ Date of Return \_\_\_\_\_

**Please indicate, in order of visit, the places you will go and how long you will stay. Include cities/countries where you have only an airport "layover".**

Destination (City, Country)	Length of stay
_____	_____
_____	_____
_____	_____

With whom are you traveling?

**Where will you be staying? (Please check (✓) all that apply)**

- |  |  |                                      |                                       |
|--|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Major Resort Hotel        | <input type="checkbox"/> Rented Foreign Home | <input type="checkbox"/> Dormitory   | <input type="checkbox"/> Youth Hostel |
| <input type="checkbox"/> Staying in a private home | <input type="checkbox"/> Cruise Ship         | <input type="checkbox"/> Small Hotel | <input type="checkbox"/> Camping      |
| <input type="checkbox"/> Safari                    | <input type="checkbox"/> Rural Travel        | <input type="checkbox"/> Other _____ |                                       |

**Reason for travel:**

- |  |   |                                     |  |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Business        | <input type="checkbox"/> Student          | <input type="checkbox"/> Field Work | <input type="checkbox"/> Hospital Relief |
| <input type="checkbox"/> Teacher         | <input type="checkbox"/> Volunteer Worker | <input type="checkbox"/> Missionary | <input type="checkbox"/> Diving          |
| <input type="checkbox"/> Hunting/Fishing | <input type="checkbox"/> Vacation         | <input type="checkbox"/> Climbing   | <input type="checkbox"/> Visit Family    |
| <input type="checkbox"/> Other _____     |   |                                     |  |

**MEDICAL HISTORY**

**Do you currently have or have you ever had the following:**

Cancer, Leukemia, Lymphoma, other malignancies	Yes	No	Eye disease (Retinal)	Yes	No
Deficiency of the immune system (Compromised or suppressed immunity, e.g., chemotherapy, HIV, AIDS, radiation, etc.)	Yes	No	Kidney disease	Yes	No
Guillain-Barré or Myasthenia Gravis	Yes	No	Liver disease	Yes	No
Thymus problems	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Lung disease	Yes	No
Bleeding disorders	Yes	No	Heart disease	Yes	No
Psoriasis	Yes	No	High Blood Pressure	Yes	No
			Seizure disorders	Yes	No
			Intestine or Stomach (gastric) disorders	Yes	No
			Depression	Yes	No

Other medical conditions (please list): \_\_\_\_\_

**Are you pregnant, suspect that you might be, or trying to become pregnant?    Yes    No**

**Are you breastfeeding?    Yes    No**

**ALLERGIES**

**Are you allergic to any of the following? (Please mark all that apply)**

Aluminum/Alum	Yes	No	Not Sure	Mercury (Thimerosal) (Phenol)	Yes	No	Not Sure
Yeast	Yes	No	Not Sure	Sunlight	Yes	No	Not Sure
Feathers	Yes	No	Not Sure	Milk (or lactose intolerant)	Yes	No	Not Sure
Eggs	Yes	No	Not Sure	2-phenoxyethanol (preservative)	Yes	No	Not Sure
Grass/Molds	Yes	No	Not Sure	Antibiotics - (Neomycin, Streptomycin, Polymyxin B)	Yes	No	Not Sure
Vaccines	Yes	No	Not Sure				
Medications	Yes	No	Not Sure	Formaldehyde (Formalin)	Yes	No	Not Sure

List: \_\_\_\_\_

**MEDICATIONS**

**Please list all current medications? (Include the Reason for prescription medications)**

Pharmacy: \_\_\_\_\_ Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Have you taken any steroids in the past 8 weeks?      Yes      No**

**Do you drink alcohol?      Yes      No      Do you Smoke?      Yes      No**

**IMMUNIZATIONS**

**Please mark the appropriate answer and fill in the blank as necessary:**

Have you ever had a reaction to any vaccine?	Yes	No	Not Sure
Have you had Rubella (German Measles), Mumps, or Rubeola ("Red Measles")? If yes, when? _____	Yes	No	Not Sure
Have you had Rubella, Measles, or Mumps vaccines (in various combinations or as MMR)? If yes, when? _____	Yes	No	Not Sure
Have you had at least 3 doses of a polio vaccine? When? _____	Yes	No	Not Sure
When was your last tetanus shot? _____	Yes	No	Not Sure
Was it Td (tetanus/diphtheria) or Tdap (includes pertussis)	Td	Tdap	
When was your last tuberculin skin test? _____	Yes	No	Not Sure

**Please indicate if you have had any of the following vaccines and, if so, when you received them.**

Twinrix A/B combo (series of 3) or _____	Yes	No	Not Sure
Hepatitis A (series of 2) _____	Yes	No	Not Sure
Hepatitis B (series of 3) _____	Yes	No	Not Sure
Flu _____	Yes	No	Not Sure
Pneumococcal ("pneumonia") _____	Yes	No	Not Sure
Typhoid (oral or injection) _____	Yes	No	Not Sure
Yellow fever _____	Yes	No	Not Sure
Cholera _____	Yes	No	Not Sure
Meningococcal _____	Yes	No	Not Sure
Malaria prevention/treatment _____	Yes	No	Not Sure
Immune Globulin _____	Yes	No	Not Sure
Other _____	Yes	No	Not Sure

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Date*

*Information reviewed with client by:*

\_\_\_\_\_  
*RN Signature*

\_\_\_\_\_  
*Date*