Patient Sticker

DENVER HEALTH TRAVEL CLINIC
A Service of Denver Public Health

TRAVELER INFORMATION & MEDICAL HISTORY FORM

- **Please complete entire form.**
- **REMEMBER! Please bring all of your shot records to your clinic appointment.**

Insurance Provider:
_____

DENVER HEALTH MEDICAL PLAN
Yes_____ No_____

NAME: _____, _____, _____
(Last) (First) (Middle)

DATE OF BIRTH: _____/_____/_____
(Month) (Day) (Year)

PARENTS NAME (if under 18) _____ _____ **Male** _____ **Female**

HOME PHONE: _____ **DAYTIME PHONE:** _____

TRAVEL DATES: Date of Departure: _____ **Date of Return:** _____

List each Country in order:	Length of Stay:	Urban:	Rural:
Location #1: _____	_____	_____	_____
Location #2: _____	_____	_____	_____
Location #3: _____	_____	_____	_____
Location #4: _____	_____	_____	_____

Provider Notes:_____

PURPOSE OF TRAVEL (Circle all that apply):

Vacation	Student	Medical/Health	Scientific
Business	Volunteer	Mission Work	Other: _____

Provider Notes:_____

_____

ACCOMODATIONS AND ACTIVITIES (Circle all that apply):

Major hotels	Stay with my family	Cruise ship	Camping
Small hotels	Stay with local residents	Safari	Diving
Rented home	Hotel / Dorm	Trekking	Other: _____

Provider Notes:_____

MEDICAL / TRAVEL HISTORY

Have you traveled previously outside the U.S.? __Never ___Once ___Several Times ___Extensively

Please check YES or NO to the following questions:

IMMUNIZATIONS	YES	NO	*PROVIDER NOTES/PRECAUTION*
Have you ever fainted from having your blood drawn, giving blood, or from having an injection?			
Have you ever had any reaction to vaccination? If so please explain.			
Do you live (or work closely) with anyone who has an immune disorder such as HIV/AIDS or who is on chemotherapy for cancer?			
Have you received any injection of immune globulin or any blood product during the last 12 months?			
Have you had any vaccines in the last month? If so, which one/s?			

GENERAL MEDICAL	YES	NO	*PROVIDER NOTES/PRECAUTION*
Do you have a medical condition that warrants maintenance medications or physician follow up? If yes, please list: _____ _____			
Do you have a medical condition that is stable now, but that may recur while traveling?			
Have you had a fever in the past 48 hours?			
Do you have HIV, AIDS, an AIDS-like condition, any other immune disorder, leukemia or cancer?			
Do you have any blood disorders, or are you taking a “blood thinner”?			
Have you ever had a convulsion, seizure, epilepsy, neurologic condition or brain infection?			
Do you have any stomach or bowel conditions such as diarrhea or constipation?			
Have you ever had hepatitis or yellow jaundice?			
Do you have a history of depression, anxiety, or any psychiatric problem?			
Do you have a problem with strange dreams and/or nightmares?			
Do you have problems with yeast infections when using antibiotics?			
Do you have psoriasis?			

Please list any medical condition we may not have asked about.

MEDICATIONS	YES	NO	*PROVIDER NOTES/PRECAUTION*
Have you ever taken a medication to prevent malaria?			
Did you tolerate the malaria medication?			
If you took malaria medical, please list which one/s.			
What, if any side effects did you experience?			
Please list all prescriptions or over the counter medications you are currently taking or will be taking on this trip. Please include frequency and dosage.			

ALLERGIES	YES	NO	*PROVIDER NOTES/PRECAUTION*
Are you allergic to any of the following?			
Medications including antibiotics			
Foods including yeast or eggs			
Preservatives			
Environmental- (latex, Seasonal grass/pollen/mold)			
Insect bites/bees			
Other			

WOMEN ONLY	YES	NO	* PROVIDER NOTES/PRECAUTION*
Date of last menstrual period?			
Are you pregnant?			
Are you breastfeeding?			
Planning to become pregnant on this trip?			
Method of birth control?			

ADDITIONAL COMMENTS OR CONCERNS:

NOTE: Any "precaution" listed above may be a contraindications or merely a precaution that warrants further discussion between the health care provider and patient The "precaution" list is not all-inclusive but is representative of common issues that arise in a pre travel consultation..

All of the information included on the Traveler information & Medical History Form has been reviewed with the traveler and/or the traveler's guardian. I, the traveler or the traveler's guardian, certify that the above information is accurate to the best of my knowledge.

SIGNATURES: _____ _____

(TRAVELER OR TRAVELER'S GUARDIAN AND DATE) (DENVER HEALTH PHN AND DATE)