Travel Medicine Clinic

Phone (832)822-1038
Fax (832) 825-1281

Please complete and return via fax or email

https://www.texaschildrens.org/departments/travel-medicine

Patient Name: ______________________________________ Phone: ______________________________

Date of Birth: _____________________ Age: ___________ Gender: ◻ Male ◻ Female

Pharmacy Name: ___________________________________ Phone: ______________________________

Emergency Notification
Name: ____ Phone: ______________________________

Relationship: ______________________________________

Referral Source
◻ Self ◻ Physician ◻ Employer ◻ Other

Travel Information
Departure Date: ____________________________________ Total Length of Trip: __________________

Please list in chronological order the cities and countries you are scheduled to visit. Be as specific as possible. This information is helpful in determining your health risks.

Country	City	Arrival Date	Departure Date	Area Type
________________	________________	_________________	________________	◻ Urban ◻ Rural
________________	________________	_________________	________________	◻ Urban ◻ Rural
________________	________________	_________________	________________	◻ Urban ◻ Rural
________________	________________	_________________	________________	◻ Urban ◻ Rural
________________	________________	_________________	________________	◻ Urban ◻ Rural

What is the purpose of your travel? (Check all that apply)

◻ Business ◻ Relocation ◻ Missionary/Volunteer ◻ Medical Work
◻ Vacation ◻ Study/Teaching ◻ Visiting Friends/Relatives ◻ Adoption
◻ Other ____

What activities do you have planned? (Check all that apply)

◻ Hiking ◻ Climbing ◻ Rafting ◻ Caving/Spelunking
◻ Safari ◻ Scuba Diving ◻ Biking or Running ◻ Animal Contact
◻ Construction ◻ Other ____

Where will you be staying? (Check all that apply)

□ Hotel/Resort □ Camp/Tent □ Cruise ship □ Compound
□ Private home □ Other ____

Will any accommodations NOT have air conditioning?	□ Yes	□ No
Will you be staying or eating with local families?	□ Yes	□ No
Will your travel include rural areas?	□ Yes	□ No

Medical History

Are you being treated for any medical conditions: □ Yes □ No

____

____

Medications:

____

____

Do you have any of the following conditions? Check "Yes" or "No"

	Yes	No		Yes	No
Seizures/Epilepsy	□	□	Cancer	□	□
Nightmares/Night Terrors	□	□	HIV Infection	□	□
Depression/Psychiatric Disorder	□	□	Immune Disorder/Autoimmune	□	□
G6PD Deficiency	□	□	Psoriasis	□	□
Hemophilia	□	□	Arrhythmia (irregular heartbeat)	□	□
Sickle Cell	□	□	Guillan Barre Syndrome	□	□
Stomach/Intestinal Problems	□	□	Myasthenia Gravis	□	□
Motion Sickness	□	□	History of Altitude Sickness	□	□

Are you currently taking prednisone, cortisone or some other steroid?	□ Yes	□ No
Have you received blood products or immune globulin in the past 12 months?	□ Yes	□ No
Are you pregnant, planning to be pregnant or breastfeeding?	□ Yes	□ No

Do you have any allergies? □ Yes □ No

If yes, what are you allergic to?

____

____

Have you ever required an Epi-Pen or an ER visit for an allergy?	□ Yes	□ No
Have you ever had a reaction to a vaccine?	□ Yes	□ No

Please Explain: ____

Have you ever received any vaccines for travel? ◻ Yes ◻ No

If yes, please list: ____

Immunization History

List the dates of your vaccines. Otherwise, check "Had Disease" or "Unknown". If you have your immunization records, you may attach them instead of completing this form.

	Vaccine Dates				
	#1	#2	#3	Had Disease	Unknown
Hepatitis A	________	________	________	◻	◻
Hepatitis B	________	________	________	◻	◻
Measles, Mumps, Rubella (MMR)	________	________	________	◻	◻
Polio	________	________	________	◻	◻
Tetanus (Td or Tdap)	________	________	________	◻	◻
Varicella (chicken pox)	________	________	________	◻	◻
Meningococcus (meningitis)	________	________	________	◻	◻
Pneumococcus (pneumonia)	________	________	________	◻	◻
Influenza	________	________	________	◻	◻
Typhoid (Oral)	________	________	________	◻	◻
Typhoid (injection)	________	________	________	◻	◻
Japanese Encephalitis	________	________	________	◻	◻
Yellow Fever	________	________	________	◻	◻
Rabies	________	________	________	◻	◻

Signature: ____ Date: ____________________