**Travel Health History Form**

**\*Please read this page carefully before completing\***

**You will be asked to provide the following information:**

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| 1. General Information (name, address, phone, etc.)
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| 1. Travel Plans – include each location you will be visiting on your trip in order of when you will visit
 |
| 1. Health History – we ask for important information that the pharmacist needs in order to provide you safe and accurate recommendations
 |
| 1. Vaccination History – to the best of your ability, provide a record of different shots you have received
 |
| 1. Consent to treat/HIPAA
 |

**Tips for Form Completion**

* Gather your medical history including all medications and dates of all vaccinations
* Check your travel plan and confirm correct spelling of all countries, regions/states, and cities. If needed, do an internet search on the country to obtain accurate information. See below for helpful websites:

<http://www.un.org/Depts/Cartographic/english/htmain.htm>
<http://www.lib.utexas.edu/maps/map_sites/country_sites.html>
* List each country (including airport stops) or unique travel activity location separately and **IN ORDER**! The need for some vaccinations is based upon where were before visiting certain countries!
* **Cruise ship travelers** - Please list EACH country you will be visiting or stopping at IN ORDER.
* There is space at the end of this document to write additional information if you run out of room

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| **General Patient Information****Please complete this form and submit to mymeds@pitt.edu as soon as possible** |
| Do you have health insurance provided through the University of Pittsburgh for the patient listed on this form? [ ]  yes [ ]  no**If you selected “no,” please do NOT complete the rest of this form.** Name (exactly as it appears on passport):Click or tap here to enter text. DOB: Click or tap here to enter text. Sex: Click or tap here to enter text. [ ]  I prefer not to disclose Name of guardian (if applicable): Click or tap here to enter text.Preferred Phone:Click or tap here to enter text. [ ]  mobile [ ]  home [ ]  work Alternate Phone: Click or tap here to enter text. [ ]  mobile [ ]  home [ ]  workHome Address: Click or tap here to enter text. City: Click or tap here to enter text. State: Click or tap here to enter text. Zip: Click or tap here to enter text.Email: Click or tap here to enter text.Primary Care Physician (or physician who provides most medicine): Click or tap here to enter text. Primary Care Physician phone/fax: Click or tap here to enter text.  |
|  **Travel Plans** |
| **Countries/regions/cities (in order of visit)** | **Arrival Date** | **Departure Date** |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap to enter a date. |
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| **Reason for travel (check all that apply):** [ ]  Vacation [ ]  Education/research [ ]  Adoption [ ]  Visit friends/family [ ]  Work (urban, office-based, conference) [ ]  Work (rural, outdoors, local community) [ ] Obtain medical/dental care[ ]  Mission/volunteer work [ ]  Other: Click or tap here to enter text.**Where will you stay? (check all that apply):** [ ]  Resort/large hotel [ ]  Small hotel/AirBnB [ ]  Cruise ship [ ]  Private home (with locals) [ ]  Private home (with relatives) [ ]  Private home (expatriate or high-end) [ ]  Primitive camping [ ]  Up-scale camp/lodge [ ]  Dormitory/ hostel [ ]  Other: Click or tap here to enter text.**What type(s) of areas will you visit?:** [ ]  rural [ ]  urban [ ]  remote **Will you climb to high altitudes (8,000 feet or higher)?** [ ]  Yes [ ]  No [ ]  Not sure**Will you be exposed to body fluids (example: performing or having medical/dental work):**  [ ]  Yes [ ]  No [ ]  Not sure**Will you be working with animals?** [ ]  Yes [ ]  No [ ]  Not sure**Will you have new sexual partners?** [ ]  Yes [ ]  No [ ]  Not sure |
| **Health History****(Check all that apply)** |
| **Allergies:** please describe reaction [ ]  Antibiotics (example: penicillin, sulfa): Click or tap here to enter text.[ ]  Other medications: Click or tap here to enter text.[ ]  Egg [ ]  Latex [ ]  Gelatin [ ]  Yeast [ ]  Bees/wasps [ ]  Seasonal [ ]  Other:Click or tap here to enter text.[ ]  Side effects or reactions from previous medicine (e.g., nausea, dizziness, stomach upset): Click or tap here to enter text.**Cancers/blood disorder**[ ]  Blood clotting disorder[ ]  Cancer * Type(s): Click or tap here to enter text.
* Active or remission?Click or tap here to enter text.

[ ]  History of blood clot[ ]  Other: Click or tap here to enter text.**Endocrine** [ ]  Diabetes [ ]  Thyroid disease [ ]  Other: Click or tap here to enter text.**Gastrointestinal**[ ]  Crohn’s disease or ulcerative colitis[ ]  Irritable bowel syndrome (IBS) [ ]  Gastroesophageal reflux disease (GERD) [ ]  Chronic hepatitis [ ]  Liver cirrhosis or liver failure [ ]  Other: Click or tap here to enter text.**Heart/circulation** [ ]  Arrhythmia (heart rhythm problem including atrial fibrillation, heart block) [ ]  Pacemaker or defibrillator [ ]  Heart attack [ ]  High cholesterol [ ]  High blood pressure [ ]  Stroke [ ]  Other: Click or tap here to enter text. | **Immune system**[ ]  Steroids by mouth in past 3 months [ ]  Immune suppressive medicines or treatments in past 3 months (examples: radiation, cancer chemotherapy drugs) [ ]  Spleen removed [ ]  Thymus disease or thymectomy [ ]  HIV/AIDS * T-cell count/date collected: Click or tap here to enter text.

[ ]  Organ, bone marrow, stem cell transplant * Organ type: Click or tap here to enter text.

[ ]  Other: Click or tap here to enter text.**Kidneys** [ ]  Dialysis [ ]  Kidney insufficiency [ ]  Other: Click or tap here to enter text. **Lungs** [ ]  Asthma [ ]  Chronic Obstructive Pulmonary Disorder (COPD)[ ]  Current or history of tuberculosis[ ]  Other: Click or tap here to enter text.**Musculoskeletal** [ ]  Rheumatoid Arthritis (RA) [ ]  Psoriatic arthritis [ ]  Other: Click or tap here to enter text. **Neurologic/psychiatric** [ ]  Seizures or epilepsy[ ]  Anxiety /depression[ ]  History of Guillain-Barré [ ]  Other: Click or tap here to enter text. **Reproductive Health**[ ]  Pregnant: Click or tap here to enter text.weeks/trimester[ ]  Breastfeeding [ ]  Planning to become pregnancy in next 3 months [ ]  Other: Click or tap here to enter text.**Skin** [ ]  Psoriasis [ ]  Other: Click or tap here to enter text.  |
|  **Vaccination History** **(complete to the best of your ability)** |
| **During the first 5 years of your life, did you grow up in the United States?** [ ]  yes [ ]  no* **If no,** **did you have routine vaccinations prior to entering the United States?** [ ]  yes [ ]  no

**Most recent international travel (when/where):** Click or tap here to enter text.**Do you have verification of your vaccinations?** [ ]  yes [ ]  no**Have you ever had a negative reaction to a vaccination?** [ ]  no [ ]  yes, explain: Click or tap here to enter text.**Have you received the following vaccinations?**

|  |  |
| --- | --- |
| **Hepatitis A**[ ]  Yes [ ]  No [ ]  Not sure **If yes**, **did you receive 2 doses?** [ ]  Yes [ ]  No  | **MMR (measles, mumps, rubella)** [ ]  Yes [ ]  No [ ]  Not sure |
| **Hepatitis B** [ ]  Yes [ ]  No [ ]  Not sure**If yes**, **did you receive 3 doses?** [ ]  Yes [ ]  No  | **Polio** [ ]  Yes [ ]  No [ ]  Not sure**Did you receive this as an adult?** [ ]  Yes [ ]  No  |
| **Influenza (flu)**[ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. | **Tetanus (TD or Tdap)**[ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. |
| **Japanese Encephalitis** [ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. | **Typhoid** [ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. |
| **Meningococcal (meningitis)** [ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. | **Yellow Fever** [ ]  Yes [ ]  No [ ]  Not sure**If yes**, **list approximate date:** Click or tap here to enter text. |
| **Other vaccines not listed above (eg. shingles, pneumonia, etc.):** Click or tap here to enter text. |

**Have you had any of the illnesses listed above for which vaccines are available?** [ ]  Yes [ ]  No * **If yes, which illness and when**? Click or tap here to enter text.
 |
|  **Medication History** **Please list all current medications including over the counter (OTC) products, vitamins/supplements and herbal products below. Include dose and directions.** |
| **Drug**  | **Dose** | **Directions**  |
| Example: simvastatin  | 20 mg | 1 tablet by mouth in the evening  |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **Additional Information****Please include additional comments, questions, or concerns in the space below.** |
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that the information I provided above is used for my medical health assessment in determining if medical services received by the CMM Travel Health benefit are safe and appropriate based on my current health status. I understand that providing incorrect information can lead to a delay in diagnosis and can be dangerous and potentially fatal to my health. It is my responsibility to inform the doctor’s office of any change in my medical status.

**Signature of patient or legal guardian**: Click or tap here to enter text.

**Printed name of signature:** Click or tap here to enter text.

**Date**:Click or tap here to enter text.

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| **HIPAA PRIVACY CONSENT**  |
| By initialing below the patient named on page 2 of this packet or the guardian of the patient understands that: • Protected health information may be disclosed or used for treatment, payment or health care operations • The CMM Travel Health benefit has a “Notice of Privacy Practices” document and the patient/guardian has the opportunity to review this notice • The CMM Travel Health benefit reserves the right to change the Notice of Privacy Practices at any time • The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions • The patient may revoke this Consent in writing at any time and all future disclosures will then cease **Your Initials:**Click or tap here to enter text. **Date**: Click or tap to enter a date. |