UCONN HEALTH

UConn Medical Group
Division of Infectious Disease
International Travelers Medical Service

(Patient Identification)

PRE-TRAVEL ENCOUNTER NOTE

To Be Completed by Traveler

PLEASE BRING YOUR IMMUNIZATION HISTORY FROM YOUR PRIMARY CARE PROVIDER TO YOUR APPOINTMENT.

YOUR APPOINTMENT WILL BE DELAYED WITHOUT THIS INFORMATION

Patient Information:

Name: _____ Birth Date: _____ Country of Birth: _____

AGE: _____ SEX: M ____ F ____ HEIGHT:_____ WEIGHT: _____

Home Address: _____

Preferred Phone Contact Number: _____

Pharmacy: _____

Allergies: Do you have allergies to the following (check all that apply): Latex ___ Neomycin ___

Penicillin ___ Streptomycin ___ Sulfa (Bactrim) ___ Bee/Wasp stings ___ Eggs ___ Yeast ___

Please describe allergic reaction (i.e. rash, swelling, etc.): _____

Are there any other drugs to which you had an allergic reaction? (Please list)

_____

Have you had any prior adverse reactions to injections? ___ Yes ___ No

Have you had any other allergic reactions: ___ Yes ___ No

If yes, please explain: _____

To Be Completed by Traveler	Physician Use Only
Medical History – Please list all medication you are currently taking (including vitamins, herbal medications, or over-the-counter medications): _____ _____ _____ _____ Please check all medical conditions that apply: ___ Cancer ___ Chronic lung disease ___ Diabetes _____Heart Disease ___ Hepatitis ____ High Blood Pressure ___HIV ___Leukemia ___ Mental Health Condition ___ Ulcer disease of stomach or duodenum Please list any other medical conditions that you have been treated for or take medication for :_____	

HCH1534

(Patient Identification)

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Medical History (con't)

If history of cancer, when was your last chemotherapy/radiation therapy?
Year _____
Are you currently taking Prednisone, Cortisone, Imuran, or Cyclosporine?
(Circle all that apply)
Are you currently taking medications for rheumatologic, dermatologic or immunosuppressive conditions? If yes, please list: _____

Are you currently taking antacid medication? ___ Yes ___ No
Prior International Travel to developing areas? ___ Yes ___ No
Have you had any prior travel related illness (i.e. malaria, diarrhea, etc.)?
___ Yes ___ No

FOR WOMEN ONLY:
Are you pregnant, suspect that you are pregnant or trying to become pregnant?
___ Yes ___ No
Last menstrual period: _____
Contraception used: _____
Are you breastfeeding? Yes ____ No ____

Travel Information:

SEE ATTACHED ITINERARY_____

Date of Departure: _____ Date of Return: _____

DESTINATION(s) in order of Travel: (Country, regions, cities, etc.) and length of stay.

Country, City, Region	Length of stay
_____	_____
_____	_____
_____	_____
_____	_____

Nature of Travel: (check all that apply):
____business ____ pleasure ____ visiting family/friends ____ study
____ teaching ____ missionary ____ service ____ safari
____camping ____ trekking ____ diving _____ visiting only tourist areas
____ visiting rural areas ____ "straying from the beaten path"

If traveling with an organization group, have you been notified of any specific medications or vaccinations you will need for this trip (e.g. need for malaria medication, vaccinations, etc.)
_____ _____

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Travel Information (con't): **Accommodations**: (check all that apply): ____ boat/ship ____ hotel ____hostel ____ host family ____tent _____ lodge ____ other ____ unsure		
Immunization History: ***** CAN REFER TO ATTACHED IMMUNIZATION RECORD _____**	**Product and Dates Administered**:	
Hepatitis A (HAVRIX, HEPTAVAX)		
Hepatitis B		
Japanese Encephalitis		
Measles (MMR)		Born <1957___; Disease ____; 1 dose ____; 2 dose ____
Meningitis (MENACTRA, MENOMMUNE, GROUP B)		
Pneumonia (PNEUMOVAX, PCV-13)		
Polio		None ___; 1 ___; 1 & booster _____
Rabies		
Tetanus (Tdap or dT)		>10 yrs ___; >5&<10___; <5yr___
Typhoid (ORAL or INJECTABLE)		
Varivax		
Yellow Fever		
Zoster		
Other Vaccines (please describe)		

TRAVELER SIGNATURE: _____ DATE/TIME: _____

PROVIDER SIGNATURE: _____ DATE/TIME: _____