Kelsey-Seybold Clinic
Changing the way health cares.

TRAVEL MEDICINE QUESTIONNAIRE

Patient information (please print)

Legal Name of Traveler:	DOB:	Gender (circle): M F
(First)__________________________	________/_______/_______	Place of Birth:
(Middle)________________________	Month Date Year	________________________________
(Last)__________________________		City State Country

Address:	Street: ____ City: ___________________ State: ____________ Zip: _________
Patient's Phone Number:	______-______-______
Primary Health Care Provider:	Name: ____ Phone: ____
Emergency Contact:	Name: _________________________________ Relationship: _________________ Phone: ____

Itinerary

Date of Departure:	______/____/______ Month Date Year	Duration: _______________________days/weeks/months (circle one)
Return Date:	______/____/______ Month Date Year	

Purpose of Travel (check all that apply):

__Vacation	__Teaching	___Field Work	___Relocation
__Missionary Work	__Study	___Diving	___Other (specify):
__Business	__Safari	___Climbing	____________________

Type of Travel (check all that apply):		Accommodations (circle all that apply):	
___Group Tour	____Cruise	____Compound	___Private Home
___Flexible Itinerary	____Fixed Itinerary	____Hotel	___Cruise Ship
___Independent	Other (specify): ___________________	____Resort	___Offshore Rig

Destinations (include stopovers, list in order of travel):

Country	City	Duration (dates)	Urban (✔)	Rural (✔)

Notice of advance payment required.

This notice is to inform you that most health plans do not offer coverage for immunizations for the purpose of travel. Therefore, Kelsey Seybold Clinic will not file a claim for this visit with your health plan. Payment in full is expected at the time of your visit. Further, these services are not subject to any existing discount policies. You may choose to file a claim directly with your health plan. You may also choose to contact your health plan prior to visit to request a benefits review for "Travel Medicine Services". If you can bring written proof from your health plan showing evidence of coverage for travel medicine service, Kelsey Seybold Clinic will file the claim on your behalf.

I verify that the above information is complete and correct to the best of my knowledge.

Signature X: ____ **Date X**: ____________________

Immunization history (Check had disease if applicable or list date of appropriate vaccination

	Had disease	Vaccine #1 date	Vaccine #2 date	Vaccine #3 date	Not known		Had disease	Vaccine #1 date	Vaccine #2 date	Vaccine #3 date	Not known
Chickenpox/Varicella						**Rubella**					
COVID-19						**Meningitis**					
Cholera						**Polio**					
Hepatitis A						**Pneumococcal**					
Hepatitis B						**Influenza**					
Rabies						**Tetanus/Diphtheria**					
Japanese Encephalitis						**Typhoid injection**					
Measles						**Typhoid Oral**					
Mumps						**Yellow fever**					

1. Do you have an “International Certificate of Vaccination or Prophylaxis” (ICVP or Yellow Book): ____ YES____NO
2. Have you ever fainted or had an adverse reaction to any injections? ____ YES____NO
3. Do you have cancer, leukemia, AIDs, or other immune system problems? ____ YES____NO
4. Do you take cortisone, prednisone, other steroids, anti-cancer drugs or have, radiation therapy, or any oral/injectable immunobiologic agents? ____YES ____NO
5. Have you received a blood transfusion, blood products or immune globulin in the past year? ____ YES___ NO
6. Do you have history of anaphylactic reaction from insect bites? _____YES ___NO
7. **Any vaccines in the past 8 weeks? If yes, please state which vaccine(s).** ____________________________________

Health History (List date if applicable):

Any allergies to medications: ____

Medical Conditions: ____

Surgical History: ______________________________________ **Recent hospitalization (last 3 months)** _______________

History of any of the following (select all that apply):

- ☐ Nightmares
- ☐ Seizure/epilepsy
- ☐ Depression
- ☐ Psoriasis
- ☐ Psychiatric disorders
- ☐ Stomach/Colon Problems

Women:

1. Last Menstrual Period: _____/_____/_____
2. Are you currently pregnant? __ YES __NO
3. Are you planning pregnancy in the next 3 months? __YES___NO
4. Any contraception? __YES__ NO

Medications (List all including dose):

Prescription:

1.____
2.____
3.____
4. ____
5. ____

Non-Prescription/Over the Counter:

1. ______________________________________
2. ____
3. ____
4. ____
5. ______________________________________

I verify that the above information is complete and correct to the best of my knowledge.

X ______________________________
Signature

X ______________________________
Date