Kelsey-Seybold Clinic®
Changing the way health cares.℠

Travel Medicine Questionaire

Patient information (please print)

Legal Name of Traveler:	DOB:	Gender (circle): M F
(First)________________	______/______/______	Place of Birth:
(Middle)________________	Month Day 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 Day Year	Duration: ________________ days weeks months (check one)
Return Date:	______/______/______ Month Day 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):

Group Tour	Cruise
Flexible Itinerary	Fixed Itinerary
Independent	Other (specify): ________________

Accommodations (check all that apply):

Compound	Private Home
Hotel	Cruise Ship
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: ________________________________ Date: ________________

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 4 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
5. Are you nursing? ______ YES ______NO

Health History (List date if applicable):

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.

Signature: ____ Date: ______________________________