OptiMed HEALTH PARTNERS

ACCREDITED Specialty Pharmacy Expires 12/01/2018

INTERNATIONAL TRAVEL MEDICINE PATIENT INFORMATION SHEET

Today's Date: Date of Departure:

Name: Social Security #: / /

Address: City: State: Zip:

Date of Birth: Sex: (Circle One) M F

Primary Telephone No. ( ) Secondary Telephone No. ( )

Email Address: Do you have a current passport?

INFORMATION ABOUT PLANNED TRAVEL

Purpose of Trip: If other, please specify:

Are you traveling as part of a group or organization?

If yes, what is the name of the group of organization?

Does your group or organization require the completion of a medical form by a practitioner?

What types of activities will you be doing during your trip?

Are you enrolled in a health insurance plan that covers you while overseas?

What is the name of your insurance company?

Do you have emergency evacuation insurance?

TRAVEL ITINERARY

Departure Date from U.S. Return Date to U.S.

Fill out the itinerary below in the order that you will be visiting destinations.

Country	City/Region	Purpose/Activities	Arrival Date	Departure Date

Have you ever traveled outside the U.S. before?

If yes, please provide information about this/these trip(s)?

Country	City/Region	Purpose/Activities	Approximate Travel Date	Trip Duration

For your current trip will you be:

Visiting only urban areas? If no, explain.

Staying only in hotels? If no, explain.

Visiting farms? If yes, explain.

Exposed to animals? If yes, explain.

Ascending to high altitudes (>7,000 ft or 2,300 meters) in the mountains?

Working in the medical or dental field with possible exposure to blood or other body fluids? If yes, explain.

Potentially having sexual contact with new partners?

INFORMATION ABOUT TRAVELER

Medical History

Are you currently using steroids, receiving radiation therapy or other medications that decrease your immune system? If yes, explain.

Do you currently smoke? If yes, would you like to try to quit?

Please list any active medical conditions you have and current prescription medications being used to treat these conditions.

Medical Conditions	Prescription Medications (provide dose if known)	How Long Have You Taken this Medication?

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Please list any non-prescription medications that you regularly use and the reason you take these medications.

Reason for Use	Non-Prescription Medications (provide dose if known)	How Long Have You Taken this Medication?

Have either you or a family member been told you have any of the following medical conditions? (Check all that apply)

Yes	No	Family		Yes	No	Family		Yes	No	Family	
☐	☐	☐	Anemia	☐	☐	☐	G6PD Deficiency	☐	☐	☐	Liver Disease/Hepatitis
☐	☐	☐	Asthma	☐	☐	☐	Gout	☐	☐	☐	Lung Disease
☐	☐	☐	Blood Clotting Problems	☐	☐	☐	Hearing Problems	☐	☐	☐	Prostate Problems
☐	☐	☐	Cancer	☐	☐	☐	Heart Disease	☐	☐	☐	Psoriasis/Skin Problems
☐	☐	☐	Depression	☐	☐	☐	High Blood Pressure	☐	☐	☐	Sickle Cell Disease
☐	☐	☐	Diabetes	☐	☐	☐	High Cholesterol	☐	☐	☐	Stomach Ulcer
☐	☐	☐	Frequent Ear Infections	☐	☐	☐	Hormone Problems	☐	☐	☐	Stroke
☐	☐	☐	Epilepsy/Seizures	☐	☐	☐	Weak Immune System	☐	☐	☐	Thyroid Problems
☐	☐	☐	Eye Problems	☐	☐	☐	Kidney Disease	☐	☐	☐	Other:

Allergies

Do you have allergies to any medications? If yes, explain.

Medication	Describe Reaction	Severity of Reaction

Do you have allergies to any foods? If yes, explain.

Food	Describe Reaction	Severity of Reaction

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Have you ever had an allergic reaction to any of the following? (Check all that apply)

- ☐ Eggs
- ☐ Sulfa drugs (e.g., Bactrim, Septra, Gantrisin)
- ☐ Antibiotics (e.g., Neomycin, Streptomycin)
- ☐ Pencillins (e.g., beta-lactams, cephalosporins)
- ☐ Erythromycins (e.g., azithromycin, clarithromycin)
- ☐ Tetracyclines (e.g., Doxycycline, Minocycline)
- ☐ Quinines (e.g., Chloroquine (Aralen), Mefloquine (Lariam), Hydroxychloroquine (Plaquenil), Primaquine)
- ☐ Pyrimethamine
- ☐ Thimerosal (preservative in vaccines and contact lens solution)
- ☐ Chrysanthemums

Immunization History

Were you born in the U.S.? If not, where?

Have you had the following immunizations/vaccines?

Vaccine	Yes/No	If yes, when?
Hepatitis A		
Hepatitis B		
BCG (Tuberculosis)		
Influenza		
Meningococcal		
MMR (Measles, Mumps, Rubela)		
Pertussis		
Pneumococcal		
Polio		
Rotavirus		
Tetanus		
Typhoid		
Yellow Fever		
Zoster		

For Women Only

When was your last normal menstrual period?

Are you, or could you possibly be pregnant? Would you like to have a pregnancy test performed?

Are you currently breastfeeding an infant?

Emergency Contact

In the case of an emergency, please provide information for someone who can be contacted.

Name: Relation to Traveler:
Address: City: State: Zip:
Email Address: Telephone No. ( )