TravelRx
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Pre-Travel Intake Form

Please comp lete and return via email or fax at least 24 hrs prior to your appointment

Name: _____
Last First Middle Initial

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: ____/_____/_____

Pharmacy
Name _____ **Phone** _____

Referral source: ☐ Physician ☐ Self ☐ Other _____

Reason for travel: ☐ Vacation ☐ Business ☐ Volunteer ☐ Education ☐ Adoption ☐ Visiting Friends and/ or Family

Itinerary: Departure date_____ Length of Stay _____

Please list in chronological order the **Cities and Countries** you are scheduled to visit, including layovers:

Destination ***Length of Stay***

_____

_____

_____

_____

Please answer the following questions

Are you…

Staying in air conditioned accommodations? Yes ☐ No ☐

Visiting rural areas? Yes ☐ No ☐

Visiting only urban areas? Yes ☐ No ☐

Visiting both urban and rural areas ? Yes ☐ No ☐

Staying and / or eating with locals/ friends / family Yes ☐ No ☐

Visiting usual tourist areas? Yes ☐ No ☐

Straying from the usual tourist areas? Yes ☐ No ☐

Traveling to areas greater than 24 hrs from health care? Yes ☐ No ☐

Medical History

1. Do you have any known allergies? Yes ☐ No ☐
   If yes, please list _____
2. Have you ever had a reaction to a bee sting? Yes ☐ No ☐
3. Do you have allergic reactions to eating eggs? Yes ☐ No ☐
4. Do you have allergic reactions to antibiotics? Yes ☐ No ☐
   If yes, please list _____
5. Are you currently pregnant? Yes ☐ No ☐
6. Are you being treated for any medical conditions? Yes ☐ No ☐
   If yes, please list _____

7. Do you have a history of any of the following?	Yes	No
Seizures / epilepsy		
Nightmares		
Depression		
Anxiety disorders		
Psychiatric disorders		
Immune deficiency/Disorder		
Psoriasis		
G6PD Deficiency		
Irregular heart beat / cardiac arrhythmias		
Thymus Gland surgery or disorder (e.g. myasthenia gravis)		
History of altitude sickness		

8. Are you currently taking any medications? Yes ☐ No ☐
   If yes, please list _____
9. Name of Primary Care Provider_____ Phone_____

10. Routine Immunizations: Provided by your Primary Care Provider? Yes ☐ No ☐

    Up to date? Yes ☐ No ☐ Unsure ☐

11. Have you received any immunizations in the last 4 weeks? Yes ☐ No ☐
If yes, which ones

Vaccine **Date**

_____

_____

_____

_____

_____

12. Have you ever received any vaccines for travel? Yes ☐ No ☐
If yes, which ones and when did you receive them (please list)

Vaccine **Date**

_____

_____

_____

_____

_____

_____

_____

13. Have you received immune globulin, a blood transfusion or any blood products in the last year?
Yes ☐ No ☐

_____

Signature ***Date***