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JCMG TRAVEL MEDICINE

Clinic use only: MR#_____

## JCMG Travel Clinic Patient Questionnaire

Name_____ Date of Birth_____
Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____Email_____
Occupation_____ Employer_____Work Phone_____
Primary Care Physician_____ Primary Physician's Phone_____
Travel Departure Date_____Return Date_____

For accurate travel medicine recommendations, please provide below the SPECIFIC locations to be visited:
(For additional locations, please attach a separate completed list using the same format as below.)

| Name of City or Rural area | Name of Country | Transport Mode | Dates (in order) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Reason for trip:** __Business, __Vacation, __Mission, __Other_____

| **Do you have:** | | | **If yes, please explain:** |
|---|---|---|---|
| Frequent or severe headaches | __Yes | __No | _____ |
| Chronic or frequent colds | __Yes | __No | _____ |
| High blood pressure | __Yes | __No | _____ |
| Heart problems | __Yes | __No | _____ |
| Asthma/Chronic cough | __Yes | __No | _____ |
| Gastrointestinal Disorder | __Yes | __No | _____ |
| Liver disease | __Yes | __No | _____ |
| HIV/Other Immune Disorders | __Yes | __No | _____ |
| Cancer | __Yes | __No | _____ |
| Diabetes | __Yes | __No | _____ |
| Epilepsy/seizures | __Yes | __No | _____ |
| Depression, anxiety or nervous disorder | __Yes | __No | _____ |
| Recent Surgery | __Yes | __No | _____ |
| <u>Women:</u> | | | |
| Pregnant or trying to get pregnant | __Yes | __No | _____ |
| Breastfeeding | __Yes | __No | _____ |

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**Circle any allergies you may have:** Eggs Latex Other_____
**List allergies to medicine:**_____
_____

**List medications and their dose currently taking (include over-the-counter):**_____
_____
_____
_____

**Immunization History:** (circle 'yes' or 'no' if you had the disease **OR** list date of appropriate vaccination)

| **Vaccine** | **Had Disease?** | **Vaccine dates** | | **Vaccine** | **Had Disease?** | **Vaccine dates** |
|---|---|---|---|---|---|---|
| Chickenpox | Yes No | | | Polio | Yes No | |
| Hepatitis A | Yes No | | | Pneumococcal | Yes No | |
| Hepatitis B | Yes No | | | Rabies | Yes No | |
| Influenza | Yes No | | | Tetanus/Diphtheria | Yes No | |
| Japanese Encephalitis | Yes No | | | Typhoid Injection | Yes No | |
| Measles/Mumps/Rubella | Yes No | | | Typhoid Oral | Yes No | |
| Meningitis | Yes No | | | Yellow Fever | Yes No | |

Any other pertinent medical history or situation__Yes __No If yes, please explain on separate sheet.

I certify that the above information is correct. I am responsible for payment in full at the time of service. **Travel clinic services are not billable by JCMG Travel Medicine to your insurance company.** A charge will be assessed to patients missing an appointment and/or canceling an appointment with less than 48 hours advanced notice.

Signature_____Date_____

Print Name_____

*****PLEASE BRING YOUR YELLOW TRAVEL CARD OR IMMUNIZATION RECORD TO YOUR VISIT*****