

Southwest Utah Public Health Department  
**INTERNATIONAL TRAVEL CLINIC**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ Phone # \_\_\_\_\_

Today's Date \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Date of Immigration to U.S. \_\_\_\_\_

**TRAVEL INFORMATION**

Departure Date: \_\_\_\_\_ Return Date: \_\_\_\_\_ Total length of trip: \_\_\_\_\_

Number of people traveling with you: \_\_\_\_\_ Or in your tour group \_\_\_\_\_

**ITINERARY: (List countries in Order of Travel):**

<u>Country</u>	<u>City/Area</u>	<u>Country</u>	<u>City/Area</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

**PURPOSE OF TRIP (check all that apply):**

- Business/Work     Receive medical care     Humanitarian     Visit family/friends     Other: \_\_\_\_\_  
 Vacation     Provide medical care     Missionary     Adoption

**TYPE OF TRAVEL (check all that apply):**

- Guided/escorted     Rural areas     Fixed itinerary     Usual tourist areas  
 Independent travel     Urban/major cities     Flexible itinerary     Unusual tourist areas

**PLANNED ACCOMMODATIONS:**

- Hotel 5 - 3 star     Live with locals/private home     Camping  
 Local apartment     Cruise ship     Hostels  
 Dorm style lodging     Remote location     \_\_\_\_\_

**ACTIVITIES (check all that apply to your trip):**

- Tour bus     Ocean/salt water     Altitude above 8,000 ft (2500 m)     Animal contact/hunting  
 Automobile travel     Scuba diving     Sun exposure     Field work  
 Motorcycle/bicycling     Fresh water; rivers/lakes     Caving (spelunking)     Safari  
 Cruise ship travel     Rafting/kayaking     Camping/hiking     \_\_\_\_\_

**Check any items you would like to discuss:**

- Altitude sickness     Risk of malaria     Food & water safety     Seeking medical care  
 Insect borne diseases     Traveler's Diarrhea     Motion sickness     Other \_\_\_\_\_  
 Risk of blood borne infections     Air travel/jet lag     Medical care/Evacuation Insurance

**PERSONAL MEDICAL INFORMATION**

- YES     NO - Have you previously traveled to any developing country?  
 YES     NO - Did you receive your childhood vaccines?  
 YES     NO - Have you ever had chicken pox disease or the vaccine series?  
 YES     NO - Are you currently under a physicians care for any health problem?  
 YES     NO - Do you smoke?  
 YES     NO - Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?  
 YES     NO - Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last 3 months?  
 YES     NO - Do you have any seizure or brain problems?  
 YES     NO - Have you received gamma-globulin or blood transfusions within the past year?  
 YES     NO - Have you received any vaccinations or a TB test in the past 4 weeks?  
 YES     NO - Have you ever taken anti-malarial medication? If yes, what medication: \_\_\_\_\_  
Did you tolerate it well?     Yes     No  
 YES     NO - Are you, or will you be at risk for blood borne infections such as: HIV, AIDS, or Hepatitis B and C?  
Risks include: blood transfusions, unprotected sexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.  
 YES     NO - (Females) Are you pregnant or planning on pregnancy? If yes, when: \_\_\_\_\_  
 YES     NO - (Females) Are you currently breastfeeding? If yes, how old is the infant: \_\_\_\_\_

**Allergies:**

Have you ever had a serious or life threatening allergic reaction?  YES  NO

Are you allergic to any of the following?

- Sulfa  Neomycin  Streptomycin  Polymyxin B  Eggs  Baker's Yeast  Gelatin  Bee Stings

OTHER ALLERGIES: please list: \_\_\_\_\_

**Past medical history:** (check all that apply)  NONE

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Hepatitis/Liver Disorders    | <input type="checkbox"/> Myesthenia gravis               | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Thrombophlebitis/blood clots | <input type="checkbox"/> Seizures/Epilepsy               | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Heart disease/attacks |
| <input type="checkbox"/> Recurrent pneumonia          | <input type="checkbox"/> Mental /emotional illness       | <input type="checkbox"/> Irregular heart rhythms | <input type="checkbox"/> HIV or AIDS           |
| <input type="checkbox"/> Splenectomy                  | <input type="checkbox"/> Thymus disease/thymectomy       | <input type="checkbox"/> Blood thinning meds     | <input type="checkbox"/> Psoriasis             |
| <input type="checkbox"/> Stomach or bowel conditions  | <input type="checkbox"/> Retinal or visual field changes | <input type="checkbox"/> Recent surgeries        | <input type="checkbox"/> _____                 |
- Conditions treated with immunosuppressive medications:  
such as cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis

**MEDICATION INFORMATION**

(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking

Medication	Reason for Taking

For office use only-do not fill in

**IMMUNIZATION INFORMATION**

For office use only-do not fill in

VACCINE	Date of last immunizations	For Office Use		VACCINE	Date of last immunizations	For Office Use	
		Recommend	D / D			Recommend	D / D
Chickenpox (Varicella)				MMR (0, 1 mo) Measles, Mumps, Rubella			
Hepatitis A (0, 6 mo)				Pneumococcal			
Hepatitis B (0, 1, 6 mo)				Polio IPV/OPV			
Hepatitis A & B (Twinrix) (0, 1, 6 mo) (0, 7, 21 d, 12 mo)				Rabies			
Human Papillomavirus (HPV) (0, 2, 6 mo)				Tetanus/Diphtheria Td			
Influenza				Tetanus/Diphth./Pertussis Tdap			
Gamma Globulin				Typhoid Oral			
Japanese Encephalitis				Typhoid Injectable			
Meningococcal _____				Yellow Fever			
				Zostavax (shingles)			

For Office Use

D/D = Discussed/Declined

- 1 = Not covered by insurance
- 2 = Pt feels don't need it
- 3 = Personal beliefs
- 4 = Side effects
- 5 = Will get/has from PCP
- 6 = Not enough time before travel
- 7 = Will get at destination

C = Completed Series

- V1 = Visit Date: \_\_\_\_\_
- V2 = Visit Date: \_\_\_\_\_
- V3 = Visit Date: \_\_\_\_\_

Hx = History of disease

Malaria prophylaxis recommended? Yes No, patient at low/no risk  
Prescriptions given:  YES  NO

**Southwest Utah Public Health Department- Travel Intake Form**  
*All information is strictly confidential (PLEASE PRINT)*

**CLIENT INFORMATION:**

Name: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_  
*Last First MI*

Address: \_\_\_\_\_  
*Street / P. O. Box City State Zip Code*

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Circle One: Home Cell Message Work

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Circle One: Home Cell Message Work

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
*M D YR*

Race:  White  Black  Asian  Other  Indian/Am. Native  Native Hawaiian/Pacific Islander

Hispanic/Latno:  Yes  No

Medicaid:  Yes  No ID Number: \_\_\_\_\_

Medicare:  Yes  No ID Number: \_\_\_\_\_

Private Insurance:  Yes  No Insurance Company: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

If no insurance and you wish to have assistance with the cost of vaccines:  
Gross Monthly Income: \$ \_\_\_\_\_ Number of Household/Family Member: \_\_\_\_\_

If child, name of parent: \_\_\_\_\_

**CONSENT/PRIVACY**

I, the patient (or the undersigned if other than the patient), understand that I am responsible for all expenses incurred at the Southwest Utah Public Health Department ( SWUPHD) International Travel clinic on my behalf (or on behalf of the patient). SWUPHD may be able to bill my health insurance, Medicare/Medicaid, but I understand that I am responsible for all co-payments, deductibles, immunizations, counseling fees, and other services not covered by my insurance, Medicaid/Medicare plan. I agree to pay all fees at time of service.

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated be given to the person named above for whom I am authorized to make this request. I agree that immunization information (only) may be included in a centralized, state-wide database and shared with other health care providers as necessary. I HEREBY RELEASE THE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND THEIR EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS, TRAVEL ADVICE AND PRESCRIBED MEDICATION.

I have been provided with a copy of SWUPHD's Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*For Office Use Only*  
**TRAVEL VISIT CHARGES**

\_\_\_\_\_ Consultation Fee – 1 person  
\_\_\_\_\_ Consultation Fee – More than 1 person  
\_\_\_\_\_ Missionary/Humanitarian

\$ \_\_\_\_\_ Total Consultation Fees  
\$ \_\_\_\_\_ Total Immunization Charges  
\$ \_\_\_\_\_ Other \_\_\_\_\_  
\$ \_\_\_\_\_ Amount Received

Paid By: \_\_\_\_\_  
Card / Cash / Check / Medicaid / Billed \_\_\_\_\_