PHARMACA
INTEGRATIVE PHARMACY

Travel History Form

Name: _____

Address: _____

Date of Birth: _____/_____/_____ ☐ Female ☐ Male

Main Telephone No.: (_____)_____Work Telephone No.: (_____) _____

Email Address:_____Do you have a current passport or visa? ☐ Yes ☐ No ☐ Don't Know

Signature: _____

Travel Specifics

1. Purpose of Trip: ☐ Pleasure ☐ Business ☐ Other: _____

2. What will you be doing on this trip? _____

3. Departure Date from United States:_____Return Date to United States: _____

Countries **AND** cities to be visited in order of visits	Arrival Date	Departure Date

4. Have you travelled outside the US before? ☐ Yes ☐ No
If yes, where and when? _____

5. Will you be:

Yes	No	
☐	☐	Visiting ONLY major cities? If no, explain: _____
☐	☐	Staying ONLY in hotels? If no, explain: _____
☐	☐	Visiting friends and family?
☐	☐	Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains?
☐	☐	Working in the medical or dental field with exposure to blood or other body fluids?
☐	☐	Working with exposure to animals?
☐	☐	Potentially having sexual contact with new partners?

6. What insurance coverage for prescriptions do you currently have?_____

7. Provide a copy (front and back) of your insurance card.

8. Does your health insurance plan cover you while overseas?_____ ☐ Yes ☐ No

9. Do you have medical evacuation insurance?_____ ☐ Yes ☐ No

Health History

Name of Primary Care Physician (PCP)_____

PCP phone #: _____

Allergies

1. ☐ No known drug allergies ☐ No known food allergies

2. Have you had an allergic reaction to any of the following? (please check all that apply)

- ☐ Eggs
- ☐ Sulfa Drugs (e.g. Bactrim, Septra, Gantrisin)
- ☐ Antibiotics (e.g. Neomycin, Streptomycin)
- ☐ Thimerosal (preservative in contact lens solution)
- ☐ Chrysanthemums
- ☐ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxycholoroquine [Plaquenil], Primaquine)
- ☐ Pyrimethamine
- ☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin)
- ☐ Other: _____

Immunizations

1. Were you born in the United States? ☐ Yes ☐ No If no, where? _____

2. Have you completed the following immunizations? (*Please bring your vaccination record*)

Hepatitis A	☐ Yes	when:	#1 #2	☐ No ☐ Not Sure
Hepatitis B	☐ Yes	when:	#1 #2 #3	☐ No ☐ Not Sure
Meningococcal Meningitis	☐ Yes	when:		☐ No ☐ Not Sure
MMR (Measles, Mumps and Rubela)	☐ Yes	when:		☐ No ☐ Not Sure
Polio Series	☐ Yes	when:		☐ No ☐ Not Sure
Tetanus	☐ Yes	when:		☐ No ☐ Not Sure
Typhoid	☐ Yes	when:		☐ No ☐ Not Sure
Yellow Fever	☐ Yes	when:		☐ No ☐ Not Sure
HPV	☐ Yes	when:		☐ No ☐ Not Sure
Other:_____		when:		

Medical History

1. Are you using steroids, receiving radiation therapy or other immunosuppressive chemotherapy? ☐ Yes ☐ No

2. List your current prescription medications and medical conditions treated (include birth control pills):

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

3. List regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc.)

Regularly Used Non-Prescription Medication	Condition or Reason for Use
1.	
2.	
3.	

4. Have you been told you have any of the following medical conditions (check all that apply)?

Yes	No	Family History	Yes	No	Family History	Yes	No	Family History
☐	☐	Anemia	☐	☐	G6PD Deficiency	☐	☐	Liver Disease/Hepatitis
☐	☐	Asthma	☐	☐	Gout	☐	☐	Lung Disease
☐	☐	Blood Clotting Problems	☐	☐	Hearing Problems	☐	☐	Prostate Problems
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Psoriasis/Other Skin Problems
☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐	Psychiatric Problems
☐	☐	Diabetes	☐	☐	High Cholesterol	☐	☐	Sickle Cell Disease
☐	☐	Ear Infections Chronic or Frequent	☐	☐	Hormone Problems	☐	☐	Stomach Ulcer
☐	☐	Epilepsy/Seizure Disorder	☐	☐	Immune System Deficiency	☐	☐	Stroke
☐	☐	Eye Problems (Except glasses/contacts)	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Other: _____						

5. For Women

a. Last normal menstrual period: _____

b. Are you, or could you possibly be, pregnant? ☐ Yes ☐ No

c. Are you breastfeeding an infant? ☐ Yes ☐ No

Questions/Concerns

1. Please list additional questions or concerns that you might have regarding your travel (i.e. International voltage requirements, currency exchange, dealing with seasickness, etc.) _____