# Indiana Travel Medicine

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Carmel, IN 46032
(317) 582-8182

One form per traveler please.

Traveler's Name (Last, First): _____

Date of Birth: _____ Date of Service: _____Weight: _____ lb / kg

Address:_____City_____State___Zip_____

Sex:__Male__Female Home Phone:(___)_____Work:(___)_____

Date of Departure from the US:____/___/___ Date of Return to the US: ____/___/____

Destination(s) Also list **all** intermediate stops: _____

_____

What do you plan to do there?_____

_____

_____

If the traveler is an infant, do they breastfeed, bottlefeed, or both?_____

| **Will you be:** | **Yes** | **No** | **Unsure** |
|---|---|---|---|
| Mountain Climbing? | | | |
| Visiting Rural Areas? | | | |
| Handling Animals? | | | |
| Eating Local Foods? | | | |
| Exposed to Fresh Water? | | | |
| Performing Medical or Dental Procedures? | | | |
| Performing Construction? | | | |

Please list all medications you are taking now or that you take regularly: _____

_____

Do you have any specific questions or concerns about your travel? _____

_____

_____

_____

Traveler's Name (Last, First):

Date of Birth: Date of Service:

| **Health History** | **Yes** | **No** | **Explain If "yes."** |
|---|---|---|---|
| Do you have any medical conditions (asthma, seizures, heart problems, diabetes, sickle cell anemia, etc)? | | | |
| Were you ever hospitalized or did you have any surgeries? | | | |
| Do you take any medications or have any medical devices – including contacts or eyeglasses? | | | |
| Do you have any allergies to foods, insect bites/stings, or medicines? | | | |
| Are you allergic to eggs, neomycin, streptomycin, gentamicin, thimerosal, gelatin, or sulfa? | | | |
| Have you ever had a reaction to any immunization? | | | |
| Could you be pregnant now or at the time of travel? | | | |
| Do you or any close contacts have cancer or immune system problems, including HIV/AIDS? | | | |
| Have you ever had a seizure? | | | |
| Do you have depression, or a behavior or sleep disorder? | | | |
| Do you take antacids or proton pump inhibitors? | | | |
| Do you have G6PD deficiency or any blood disorders? | | | |

Please complete the following vaccine record and bring any evidence of immunization:

| **Immunization** | **Date – #1** | **Date – #2** | **Date – #3** | **Date – #4** | **Date – #5** |
|---|---|---|---|---|---|
| DTP / DTaP | | | | | |
| Hib/Hemophilus | | | | | |
| Polio | | | | | |
| Pneumococcal | | | | | |
| Hepatitis B | | | | | |
| Hepatitis A | | | | | |
| Varicella | | | | | |
| MMR | | | | | |
| Influenza | | (List most recent vaccination – good for 1 year) | | | |
| Tetanus Booster | | (List most recent vaccination – good for 5-10 years) | | | |
| Yellow Fever | | (List most recent vaccination – good for 10 years) | | | |
| Typhoid | | (List most recent vaccination – good for 2-5 years) | | | |
| Meningococcal | | (List most recent vaccination – good for 5+ years) | | | |
| J. Encephalitis | | | | | |

I agree to pay for all goods and services rendered by Indiana Travel Medicine, and understand they may not be reimbursed by health insurance plans.

_____ _____/_____/_____

Signature of Patient (or Guardian if under 18) MO DAY YEAR