Holy Family Memorial
Sponsored by the Franciscan Sisters of Christian Charity

HFM Pharmacy
1650 S 41st Street, Manitowoc
(920) 320-4400 FAX (920) 320-5104
hfmhealth.org/travel

TRAVEL MEDICAL HISTORY QUESTIONNAIRE

Name *(Last, First, MI)*:	Phone:	Date:
Address:	Email:	

Country of Birth:	Occupation:	☐ M ☐ F	D.O.B.	Age:
Personal Physician Name:		Physician Phone:		

LEVEL OF SERVICE REQUESTED

☐ **Level 1 ($35 fee)** List vaccines and medications below. Pharmacist will screen for contraindications and appropriateness.

☐ **Level 2 ($75 fee)** Pharmacist will research itinerary and recommend vaccines and medications based on individual medical and vaccine history.

List all vaccines or medications requested: (Level 1 only)

INSURANCE INFORMATION: Please provide a copy of current prescription card.

Card Holder Name:	RX ID or Policy Number:

RX BIN	RX PCN	RX Group

TRIP INFORMATION

Have you previously traveled to a developing country? ☐ Yes ☐ No	Are you traveling alone? ☐ Yes ☐ No

If no, list who you are traveling with and ages:

Departure Date:	Return Date:

Please list in order all countries, cities, and regions you plan to visit including LAYOVERS, and the length of stay.

1.	3.
2.	4.
5.	6.
7.	8.

TRIP PURPOSE: check all that apply	ACCOMMODATIONS: check all that apply	TRIP ACTIVITIES: check all that apply
☐ Business	☐ Hotel 4 or 5 star	☐ Air travel
☐ Vacation	☐ Hotel 2 or 3 star	☐ Public transportation e.g. bus, train
☐ Study	☐ Hostel	☐ Biking
☐ Missionary	☐ Private home	☐ Rental car
☐ Visiting friends or relatives	☐ Camping	☐ Water sports e.g. swimming, boating
☐ Safari	☐ Safari	☐ SCUBA or snorkeling
☐ Cruise	☐ Staying with locals	☐ Climbing or hiking
☐ Long-stay	☐ Long-stay apartment	☐ Visiting schools, hospitals, orphanages
☐ Volunteer or humanitarian work	☐ Cruise ship	☐ Healthcare worker
		☐ Contact with animals

ALLERGIES

Medication Allergy: ☐ Yes ☐ No If yes, please list.

Vaccine Allergy: ☐ Yes ☐ No If yes, please list.

Food Allergy: ☐ Yes ☐ No If yes, please list.

Environmental Allergies e.g. hayfever, bee stings: ☐ Yes ☐ No

Other:

WOMEN ONLY

When was your last period?	Are you pregnant? ☐ Yes ☐ No	If yes, when are you due?
Are you at risk for pregnancy? ☐ Yes ☐ No	What is your method of birth control?	

IMMUNIZATION HISTORY

Do you have a written record of your vaccinations? ☐ Yes ☐ No If yes, please provide a copy with this form.

Have you had any serious reactions to vaccines? ☐ Yes ☐ No

Have you received all previous vaccines in the state of Wisconsin? ☐ Yes ☐ No

MEDICAL HISTORY

Psychiatric Problems ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Gastrointestinal Problems ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No	Heart Disease/Surgery ☐ Yes ☐ No	Respiratory Problems ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No	Immunity Problems ☐ Yes ☐ No	Immune Suppression Drugs ☐ Yes ☐ No

Other:

Please explain any "yes" answers:

Have you had any surgeries? ☐ Yes ☐ No **What kind?**

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the-counter, supplements and eye drops)

Name of Medication	Condition or reason for use	Name of Medication	Condition or reason for use
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment/administration of vaccines by the provider. I understand that payment in full by cash or credit card is due at the time of the visit. Holy Family Memorial does not bill insurance or any third party payer, including Medicare. A portion of the charges may be reimbursable by insurance.

Traveler Signature: _____ **Date:** _____

Schedule a consultation by calling HFM Pharmacy at (920) 320-4400
This completed form must be submitted to HFM Pharmacy at least 3 days in advance of your consultation.
HFM Pharmacy is located at 1650 S 41st Street, Manitowoc. You may drop the form off at our location or FAX it to (920) 320-5104.