



### HFM Pharmacy

1650 S 41st Street, Manitowoc

(920) 320-4400 FAX (920) 320-5104

[hfmhealth.org/travel](http://hfmhealth.org/travel)

## TRAVEL MEDICAL HISTORY QUESTIONNAIRE

Name <i>(Last, First, MI):</i>		Phone:		Date:	
Address:			Email:		
Country of Birth:	Occupation:	<input type="checkbox"/> M <input type="checkbox"/> 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
<input type="checkbox"/> Business <input type="checkbox"/> Vacation <input type="checkbox"/> Study <input type="checkbox"/> Missionary <input type="checkbox"/> Visiting friends or relatives <input type="checkbox"/> Safari <input type="checkbox"/> Cruise <input type="checkbox"/> Long-stay <input type="checkbox"/> Volunteer or humanitarian work	<input type="checkbox"/> Hotel 4 or 5 star <input type="checkbox"/> Hotel 2 or 3 star <input type="checkbox"/> Hostel <input type="checkbox"/> Private home <input type="checkbox"/> Camping <input type="checkbox"/> Safari <input type="checkbox"/> Staying with locals <input type="checkbox"/> Long-stay apartment <input type="checkbox"/> Cruise ship	<input type="checkbox"/> Air travel <input type="checkbox"/> Public transportation e.g. bus, train <input type="checkbox"/> Biking <input type="checkbox"/> Rental car <input type="checkbox"/> Water sports e.g. swimming, boating <input type="checkbox"/> SCUBA or snorkeling <input type="checkbox"/> Climbing or hiking <input type="checkbox"/> Visiting schools, hospitals, orphanages <input type="checkbox"/> Healthcare worker <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when are you due?
Are you at risk for pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunity Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune Suppression Drugs <input type="checkbox"/> Yes <input type="checkbox"/> 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.