TRAVEL HISTORY FORM

(Please complete this form in its entirety and Fax to 626-914-1505)

Name: _____ **Date of Birth** _____/_____/

Sex: ☐ **M** ☐ **F** **Phone**: ( ) ____ - _____ **Country of Birth**: _____

Primary Care Physician: _____

Purpose of Trip: ☐ **Business** ☐**Pleasure** ☐ **School-related Study or Work**

Countries AND Cities in Order of Visit (include return visits)	**Arrival Date**	**Departure Date**

Will you be:

■ Visiting ONLY urban areas?	☐ Yes	□ No
■ Staying ONLY in hotels?	☐ Yes	□ No
■ Working with exposure to animals?	☐ Yes	□ No
■ Working in the Medical or Dental field with exposure to blood?	☐ Yes	□ No
■ Ascending to high altitudes (greater than 7,000 feet?	☐ Yes	□ No
■ Potentially having sexual contact with new partners?	☐ Yes	□ No
■ Requiring precise manual dexterity thinking/perception or skilled	☐ Yes	□ No
physical activity (such as mountain climbing or piloting)?	☐ Yes	□ No

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

☐ Eggs ☐ Antibiotics (tetracyclines or neomycin) ☐ Thimerosal

☐ Sulfa Drugs ☐ Chrysanthemums ☐ Other allergies: _____

☐ Quinines ☐ Pyrimethamine

Have you completed the following immunizations?

■ **Hepatitis A** If yes, when? _____	☐ Yes	☐ No	■ **Tetanus/Diptheria** If yes, when? _____	☐ Yes	☐ No
■ **Hepatitis B** If yes, when? _____	☐ Yes	☐ No	■ **MMR** (Measles, mumps, rubella) If yes, when? _____	☐ Yes	☐ No
■ **Polio** If yes, when? _____	☐ Yes	☐ No	■ **Typhoid Fever** If yes, when? _____	☐ Yes	☐ No
■ **HPV** If yes, when? _____	☐ Yes	☐ No	■ **Meningitis** If yes, when? _____	☐ Yes	☐ No
■ **Vericella** If yes, when? _____	☐ Yes	☐ No	■ **Influenza** rubella) If yes, when? _____	☐ Yes	☐ No
■ **Immune Globulin** If yes, when? _____	☐ Yes	☐ No	■ **Yellow Fever** If yes, when? _____	☐ Yes	☐ No
■ **Japanese encephalitis** If yes, when? _____	☐ Yes	☐ No	■ **Pneumococcal infections** If yes, when? _____	☐ Yes	☐ No
■ **Rabies** If yes, when? _____	☐ Yes	☐ No	■ **Other (specify)** If yes, when? _____	☐ Yes	☐ No

Past and Current Medical Problems	**ALL Current Medications** (Prescription and nonprescription)

For Women Only:

When was your last normal menstrual period? _____

Are you or could you possibly be pregnant? ☐ Yes ☐ No

Are you breastfeeding an infant? ☐ Yes ☐ No