Center of
INFECTIOUS DISEASE EXCELLENCE
at River Oaks

TRAVEL MEDICINE CLINIC
PATIENT HISTORY FORM

Please fill in all areas. Use back of form if more room is needed for any category.

Full name: ______________________________

Date of birth: ____________________ **Date of visit:** ____________________

Destinations: (In order of visit)

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Departure date: ____________________

Return date: ____________________

Nature of trip: (Circle)

Urban or Rural

Medical or Non-Medical

Exposure to countryside: (Circle)

Minimal or Extensive

If you are going to work, please state what type of work and any known risks with that work:

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Past medical history

Serious medical illnesses :
Illness that caused hospitalizations, disability, lasted for a prolonged period of time, prevented you from work or recreation for prolonged periods of time.
(Circle none or list below) none

1. ______
2. ______
3. ______
4. ______
5. ______

Operations :
(Circle none or list below) none

1. ______
2. ______

Allergies or intolerance to medications:
(Circle none or list below) none

1. ______
2. ______

Hospitalizations other than for natural childbirth:
(Circle none or list below) none

1. ______
2. ______

Current medication:
(Circle none or list below) none

1. ______
2. ______

List your current physicians: (Name, address, phone number, e-mail etc.)

1. ______________________________
2. ______________________________

Bring a complete immunization record.

Tell the nurse or doctor of any current medical problems you are having, for which you are being evaluated, treated, or that might affect your trip.

List anything else that you think that the nurse or doctor should know in order to make your trip as safe as possible:

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