



400 Newport Center Drive, Suite 106
 Newport Beach, CA 92660
 Phone: 949-719-3707 Fax: 949-719-3713
 www.newportcoastpharmacy.com

Patient Travel History Form

Name: _____ Date of Birth: _____ Today's Date: _____
 Address: _____
 Home Telephone No.: (____) _____ Cell Phone: (____) _____ Male Female
 E-Mail Address: _____ Do you have a current passport or visa? Yes No

Travel Specifics

Purpose of Trip: School Related Study/Work Pleasure Business Other _____
 What will you be doing on this trip? _____

Does your program require the completion of a medical form by a practitioner? Yes No
 Are you currently enrolled in a health insurance plan that covers you while overseas? Yes No
 What insurance coverage do you currently have? _____
 Departure date from United States: _____ Return date to United States: _____

Countries AND cities to be visited in order of visits	Arrival Date	Departure Date

Have you travelled outside the United States before? Yes No
 If yes, where and when?: _____
 Will you be...
 Visiting **ONLY** urban areas? Yes No
 If no, explain: _____
 Staying **ONLY** in Hotels? Yes No
 If no, explain: _____
 Visiting friend and family? Yes No
 Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains? Yes No
 Working in the medical or dental field with exposure to blood or other body fluids? Yes No
 Working with Exposure to animals? Yes No
 Potentially having sexual contact with new partners? Yes No
 Do you currently smoke? Yes No
 If yes, how many packs per day?: _____

For Women Only:

Date of last menstrual period: _____ Are you, or could you possibly be pregnant? Yes No
 Are you breast-feeding an infant? Yes No

Allergies

- No known drug allergies No known food allergies
- Have you had an allergic reaction to any of the following? (please check all that apply)

<input type="checkbox"/> Eggs	<input type="checkbox"/> Quinines (Chlorowuine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], Primaquine)
<input type="checkbox"/> Sulfa Drugs (e.g. Bactrim, Septra)	<input type="checkbox"/> Antibiotics (e.g. Neomycin, Streptomycin, Polymyxin)
<input type="checkbox"/> Pyrimethamine	<input type="checkbox"/> Thimerosal (preservative in contact lens solution)
<input type="checkbox"/> Chrysanthemums	<input type="checkbox"/> Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin)
<input type="checkbox"/> Latex	
<input type="checkbox"/> Other: _____	

Immunizations

- Were you born in the United States? Yes No If no, where? _____
- Have you completed the following immunizations?

Hepatitis A	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Hepatitis B	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
HPV (Human Papilloma Virus)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Influenza (for current season)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Meningococcal Meningitis	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Polio Series	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Pneumococcal (Pneumonia)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Tetanus	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Typhoid	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Varicella (or history of chickenpox)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Yellow Fever	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Zoster (shingles)	<input type="checkbox"/> Yes	When: _____	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

Medical History

- Are you using steroids, receiving radiation or other immunosuppressive chemotherapy? Yes No
- List your current prescription medications and medical condition treated: (include birth control pills)

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

- List regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc.)

Current Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

- Have you been told you have any of the following medical conditions (check all that apply)?

<input type="checkbox"/> Anemia	<input type="checkbox"/> G6PD Deficiency	<input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease	_____
<input type="checkbox"/> Blood Clotting Problems	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Prostate Problems	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psoriasis/Other Skin Problem	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychiatric Problems	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sickle Cell Disease	_____
<input type="checkbox"/> Ear Infections (chronic)	<input type="checkbox"/> Hormone Problems	<input type="checkbox"/> Stomach Ulcer	_____
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Immune System Deficiency	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems	_____

Questions/Concerns

- List additional questions/concerns you might have (i.e. voltage requirements, currency conversion rates, etc.) _____