ASPETUCK HEALTH DISTRICT TRAVELER HISTORY FORM

.

Name: _____ Age: _____DOB: _____

Gender: _____ Phone #1: _____ Phone #2: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

May we email you a "traveler report" based on your itinerary? _____

Primary care physician: _____ Pharmacy and street/city/state: _____

Do you have medical evacuation insurance? _____ If using a tour group or agency, please list: _____

CT Wiz is CT's Immunization Registry that stores your vaccine history. If you do not want your vaccines submitted to CT Wiz, you must send a signed written request to the CT Dept of Health. CT Wiz also collects:

Race: _____ Preferred language: _____ Ethnicity (please circle): Hispanic or non-Hispanic

TRAVEL PLANS (list additional information on back of form if needed):

Purpose of trip and planned activities: _____

_____

Will you be*:*
Visiting areas that are:

- Rural ☐ Yes ☐ No ☐ Not sure
- Urban ☐ Yes ☐ No ☐ Not sure
- Primitive or remote ☐ Yes ☐ No ☐ Not sure

Ascending to high altitudes (8,000 ft or higher)? ☐ Yes ☐ No ☐ Not sure

Working with potential exposure to body fluids (e.g., medical or dental work)? ☐ Yes ☐ No ☐ Not sure

Working with exposure to animals? ☐ Yes ☐ No ☐ Not sure

Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

Accommodations (check all that apply):

☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise ship ☐ Private home ☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/ hostel ☐ Other _____

CITY/TOWNS AND COUNTRIES in order of visit	Arrival Date	Departure Date

Name	DOB	Date

HEALTH HISTORY (Check all that apply)

Allergies
- ☐ Antibiotics (e.g., penicillin, sulfa) _____
- ☐ Other medications _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other _____
- ☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): _____

Cancers/blood disorder
- ☐ Coagulation disorder
- ☐ History of cancer or blood disorder
- ☐ Other _____

Cardiovascular
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other _____

GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other _____

Immune system
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - Most recent CD4: _____
  - Most recent viral load: _____
- ☐ Organ, bone marrow, stem cell transplant _____
- ☐ Other _____

Kidneys
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other _____

Musculoskeletal
- ☐ RA
- ☐ Psoriatic arthritis
- ☐ Other _____

Neurologic/psychiatric
- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Other _____

Skin
- ☐ Psoriasis
- ☐ Other _____

OB/GYN
- ☐ Pregnant: _____ weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other _____

VACCINATION HISTORY
(Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

Hepatitis A	❑ Yes When? _____	❑ No	❑ Not sure
Hepatitis B	❑ Yes When? _____	❑ No	❑ Not sure
Meningococcal	❑ Yes When? _____	❑ No	❑ Not sure
Measles/Mumps/Rubella	❑ Yes When? _____	❑ No	❑ Not sure
Polio	❑ Yes When? _____	❑ No	❑ Not sure
Tetanus	❑ Yes When? _____	❑ No	❑ Not sure
Typhoid	❑ Yes When? _____	❑ No	❑ Not sure
Yellow Fever	❑ Yes When? _____	❑ No	❑ Not sure
Japanese Encephalitis	❑ Yes When? _____	❑ No	❑ Not sure
Influenza	❑ Yes When? _____	❑ No	❑ Not sure

Other _____

Have you ever had an adverse reaction to an immunization? ❑ No ❑ Yes Explain: _____

_____

Name	DOB	Date

CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:

_____

_____

_____

_____

_____

_____

_____

_____