ASPETUCK HEALTH DISTRICT TRAVELER HISTORY FORM

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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:

Patient/Client Name Date of Birth

I, _____, have been asked to receive health services via telemedicine. I understand that I will be receiving health care through interactive video conferencing equipment.

I understand that my participation in telemedicine is voluntary, and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record.

I understand that my privacy and confidentiality will be protected. When I am receiving services via telemedicine, I will be notified as to who is in the room (and/or) at the remote site.

I understand that the health care providers will have access to any relevant medical information about me, including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I understand the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters and should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911services in my community.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand.

These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I have read this document, and I hereby consent to participate in receiving health services via telemedicine under the terms described above. I understand that this document will

become a part of my medical record.

Please check the appropriate box below:

□ I agree to participate in and receive health services via telemedicine.

□ I choose NOT to participate in or receive health services via telemedicine.

This authorization, if not cancelled, will expire on (date) _____.

Date is not to exceed 12 months, event, or condition upon which this authorization expires. If blank, authorization will expire 12 months from the date of signature below.

_____

Signature of Patient/Client/Authorized (legal) representative Date

□ I have received verbal consent from the Patient/Client above or Authorized (legal) Representative for telemedicine session(s).

_____

Signature of Provider and/or Evaluator Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION:

_____

Signature of Patient/Client/Authorized (legal) Representative Date