

METHODIST TRAVEL CLINIC

10060 Regency Circle
 Omaha, Nebraska 68114
 (402) 354-1530

You may fax completed form back to (402) 354-1535



Today's Date: ____/____/____ (MM/DD/Year)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Gender: Male Female

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail address: _____

Emergency Contact: _____ Contact's Phone Number: _____

Primary Care Physician: _____ Physician's Phone Number: _____

Do you have a current passport or visa? Yes, a passport Yes, a visa No Don't Know

Travel Specifics:

1. Purpose of Trip: School Related Study/Work School/Company's Name: _____

Pleasure Business Mission Trip Other: _____

2. What will you be doing on this trip? _____

3. Does your program require completion of a medical form by a practitioner? Yes No

4. Are you currently enrolled in a health insurance plan that covers you while you are overseas?

Unsure No Yes If yes, what insurance plan do you have? _____

5. Departure Date from the United States: _____ 6. Return Date to the United States: _____

Countries and Cities to be visited in order of visits	Type of Locale (city, rural, jungle, mountain)	Arrival Date mm/dd/yy	Departure Date mm/dd/yy

7. Have you traveled outside the US before? Yes No

If yes, where and when? _____

8. Will you be visiting only urban areas? Yes No If no, explain: _____

Staying only in hotels? Yes No If no, explain: _____

Visiting friends and family? Yes No

Ascending to high altitudes (>7,000 feet or 2,300 meters) in the mountains? Yes No

Working in a medical or dental field with exposure to blood/other body fluids? Yes No

Working with exposure to animals? Yes No

Potentially having sexual contact with new partners? Yes No

Immunizations:

1. Were you born in the United States? Yes No If no, where: _____

2. Have you completed the following immunizations?

Immunization	Yes	No	If yes, when?	Immunization	Yes	No	If yes, when?
Hepatitis A				MMR (Measles, Mumps, Rubella)			
Hepatitis B				Meningococcal Meningitis			
Polio Series				Japanese Encephalitis			
Rabies Series				Influenza (current year)			
Tetanus				Yellow Fever			
Typhoid				Other (please specify)			

Medical History:

1. Are you taking steroids, receiving radiation therapy, or other immunosuppressive chemotherapy?

Yes No If yes, what? _____

2. Please list your current prescription medications and the medical conditions being treated. (include birth control pills)

Current Prescription Medications	Condition or Reason for Use

3. Please list regularly used non-prescription medications (over-the-counter, herbal, homeopathic, vitamins, etc.)

Regularly Used Non-Prescription Medications	Condition or Reason for Use

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

	Family				Family				Family		
	Yes	No	History		Yes	No	History		Yes	No	History
Stomach Ulcers				Epilepsy/Seizure Disorder				Cancer			
Kidney Disease				Ear Infections (chronic/frequent)				Stroke			
G6PD Deficiency				High Blood Pressure				Diabetes			
Sickle Cell Disease				Immune System Deficiency				Eye Problems			
Hearing Problem				Liver Disease/Hepatitis				Gout			
Lung Disease				Prostate Problems				Anemia			
High Cholesterol				Psoriasis/Other Skin Problems				Depression			
Thyroid Problems				Psychiatric Problems				Heart Disease			
Hormone Problems				Blood Clotting Problems				Asthma			

Other: _____

Allergies:

1. Have you had a reaction to any of the following? (please check all that apply)

- Eggs Sulfa Drugs (e.g., Bactrim, Septra) Chrysanthemums
- Pyrimethamine Antibiotics (e.g., Neomycin, Streptomycin)
- Thimerosal (preservative in contact lens solution)
- Quinines (Chloroquine [Aralen], Mefloquine [Lariam])
- Hydroxychloroquine [Plaquenil], or Primaquine
- Tetracyclines (Doxycycline, Minocin, Minocycline, Acromycin, Sumycin)

2. Do you have any food or drug allergies not listed above? If so, please list: _____

For Women Only:

a. When was your last menstrual period? _____

b. Are you, or could you possibly be, pregnant? Yes No

c. Are you breast-feeding an infant? Yes No

Questions or Concerns: Please list additional questions or concerns that you might have regarding your travel. (i.e. dealing with motion sickness, altitude sickness, etc.) _____

How did you hear about us?

Word of Mouth, if so who: _____

Internet, if so what website: _____ Marketing Materials: _____

Referral from your physician – Dr: _____ Other, please explain: _____

By signing below, I acknowledge that the information contained in this document is accurate and complete to the best of my knowledge.

X _____
Signature

Date

BELOW THIS LINE IS FOR OFFICE USE ONLY:

Date and time of appointment: ____/____/____ at ____ am pm