

**METHODIST TRAVEL CLINIC**10060 Regency Circle  
(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  NoAscending to high altitudes (>7,000 feet or 2,300 meters) in the mountains?  Yes  NoWorking in a medical or dental field with exposure to blood/other body fluids?  Yes  NoWorking with exposure to animals?  Yes  NoPotentially 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. If medications will be prescribed to me, I understand that the clinic is operating under a drug therapy management protocol with the medical director, and I consent to be treated following this protocol.

X \_\_\_\_\_  
Signature Date

**BELOW THIS LINE IS FOR OFFICE USE ONLY:**

Date and time of appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ am pm