PENN TRAVEL MEDICINE: PRETRAVEL WORKSHEET Today's Date_____

Last Name_____ First Name _____

Age_____ Male☐ Female☐ Date of Birth_____ Height_____ Weight _____

☐ scale ☐ pt reported

Address_____

_____

Cell # _____ Home #_____

Do you want us to send your primary care physician a copy of your immunization record? ☐ **Yes** ☐ **N**o

Primary Care Physician Name & Address: _____

Pharmacy Name, address, phone #:_____

DEPARTURE DATE_____ RETURN DATE_____

Destination(s):

Country	Weeks	Country	Weeks
_____	_____	_____	_____
_____	_____	_____	_____

Circle all that apply:

Purpose of trip: ADVENTURE, BUSINESS, EDUCATION, RELIGIOUS PILGRIMAGE, RESEARCH, TEACHING, VACATION, VOLUNTEER, OTHER_____

Accommodations: CRUISE SHIP, FIRST-CLASS HOTELS, HOMES, LOCAL HOTELS, RESORT, TENTS/CABINS, OTHER_____

Visiting: CITIES, TOWNS, COUNTRYSIDE, JUNGLE, LAKES, MOUNTAINS, PLAINS, RIVER, OTHER

_____

Special Activities: BOATING, HIKING/CAMPING, MOUNTAIN CLIMBING, SAFARI, SCUBA DIVING, SWIMMING, TREKKING, OTHER_____

Traveling above 8000 feet (2500 meters) during trip [other than flight]: ___**Yes** ____**No**

How did you hear about us? PREVIOUS CLIENT, YOUR BUSINESS, PENN PRACTICE, NON-PENN PRACTICE, PENN REFERRAL LINE, ADVERTISEMENT (where) _____
TRAVEL AGENT (Name) _____, OTHER_____

PAST MEDICAL HISTORY Please list illnesses and surgeries:

_____ _____

_____ _____

_____ _____

Last Name _____ First Name _____

CURRENT MEDICATIONS:

Medication Name	Dose	Frequency

Are you allergic to eggs? Yes No Are you immune compromised? Yes No

Females Only: Please circle response
Are you pregnant now or is there a possibility that you might be pregnant? Yes No
Are you breast feeding? Yes No

ALLERGIES:
Please note medications or other substances causing an allergic reaction. Note kind of reaction for each, for example, rash, hives, shortness of breath, nausea, vomiting.

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATION HISTORY:

Immunization	Date	Immunization	Date
Hepatitis A		Pneumovax (pneumonia)	
Hepatitis B		Rabies	
Immune Globulin		Polio	
Influenza		Tetanus-diphtheria	
Japanese Encephalitis		Typhoid (injection)	
MMR (measles, mumps, rubella)		Typhoid (oral)	
PPD (TB screen)		Varicella (chickenpox)	
Meningitis (Menactra/Menomune)		Yellow Fever	

Department use only:
Payment statement signed _____ HIPAA consent signed _____
Identification Verified _____ EPIC Questionnaire Completed _____
IDX Demographics current Yes No Updated _____