POWELL PHARMACY

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Travel History Form

Please complete this prior to your appointment. Please be as specific as possible. The information you provide will help the pharmacist prepare a personalized travel plan for you.

Patient information

Name:	DOB:	( ) Male ( ) Female
Address:		
Home Phone:	Cell Phone:	
Email:		
What Prescription do you have (bring your insurance card to appointment): BIN: PCN: ID: RxGroup #: Pharmacy help desk phone#:		

Travel Specifics

Departure date from the US: Return date to the US:

List countries AND cities to be visited in order of visits	Arrival Date	Departure Date

1. What will you be doing on this trip? _____
2. Have you traveled outside of the US before? ( ) Yes ( ) No
   a. If yes, when and where? _____
3. ( ) Yes ( ) No: Will you be visiting ONLY major cities? If no, explain: _____
4. ( ) Yes ( ) No: Will you be staying ONLY in hotels? If no, explain: _____
5. ( ) Yes ( ) No: Will you be ascending to high altitude (>7000 ft. or 2300 meters) in the mountains?
6. ( ) Yes ( )No: Will you be working in the medical or dental field with exposure to blood or other body fluids?
7. ( ) Yes ( ) No: Will you be working with exposure to animals?
8. ( ) Yes ( ) No: Does your travel program or country require the completion of a medical form by a practitioner?
9. ( )Yes ( )No: Are you currently enrolled in a health insurance plan that covers you while overseas?
10. ( )Yes ( )No: Do you have medical evacuation insurance?

Medical History

1. Allergies:
2. Are you using steroids, receiving radiation or immunosuppressive therapy? ( )Yes ( )No
3. For women ONLY:
    a. Last normal menstrual period:
    b. Are you or could you possibly be pregnant? ( ) Yes ( ) No
    c. Are you breastfeeding an infant? ( )Yes ( )No
4. Medication History:

List of current medications (Rx, OTC AND dietary). Include drug name, dosage, and direction of use	Condition used for

5. Health conditions:

Yes	No	Family History	Condition	Yes	No	Family History	Condition
			Anemia				High blood pressure
			Asthma				Hormone problems
			Blood clotting problem				Immune system deficiency
			Cancer				Kidney disease
			Depression				Liver disease/Hepatitis
			Diabetes				Lung disease
			Ear infection (chronic or frequent)				Prostate problem
			Epilepsy/Seizure problems				Psoriasis/Other skin problem
			Eye problem (excluding glasses or contacts)				Sickle cell disease
			G6PD deficiency				Stomach ulcer
			Gout				Stroke (or History of Stroke)
			Hearing problem				Thyroid problem
			Heart problem				Other:

Immunizations

1. Were you born in the United States? ( ) Yes ( ) No. If no, country of birth? _____
2. Please bring you vaccination record to the appointment
3. Please list any additional questions or concerns that you might have regarding your travel (i.e. jet lag, international voltage requirements, currency exchange, dealing with sickness, etc.)
    a.
    b.