

Northern California Travel Clinic
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1131 Gravenstein Highway South
Sebastopol, CA 95472
Phone # 707 823-3877 Fax # 707-823-3851

PLEASE PRINT AND FILL OUT. RETURN VIA FAX OR MAIL!

Name: _____ Date: _____

Street _____

City _____ Zip code (must have this!) _____

Phone Number: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Weight: _____

Family Physician: _____ Phone Number: (____) _____

Name of Pharmacy: _____ Phone Number: (____) _____

Are you completing this form for someone else? If so, is the person a child (under 18 years old)? Y/N Age of child _____ Weight of child _____

Medical History

Did you grow up in the United States? Y/N

Did you have routine childhood vaccinations? Y/N

Do you have verification or record of your vaccinations? Y/N

Do you have any of the following Allergies?

Eggs: Y/N If yes please describe reaction? _____

Other allergies (such as latex, bees, history of hives, etc.) _____

Are you pregnant or planning pregnancy? Y/N

Do you have, or have you had, any of the following illnesses or surgeries?
Please check those that apply: Diabetes_____ Emphysema_____
Heart Disease_____ High blood pressure _____ Kidney failure _____
Chronic immunosuppression (i.e. prednisone, TNF, MTX) _____
Splenectomy ____Leukemia/cancer____ If yes, still getting treatment? Y/N
Type of treatment _____
HIV_____ If yes, year diagnosed and last T-cell count _____
Neurological disease (include seizures)_____ If yes, please describe:

History of emotional problems or psychiatric illness_____ If yes please describe: _____
Any other Health concerns? _____

Please list any current medications you are on:

Destinations

1. **Each country must be listed separately** in the proper order of your itinerary. Some shots depend upon which country you are coming from before entering another country. Please take the time to insure that the order and spelling of all states, regions, cities, etc. is accurate.

2. **Cruise ships**-Identify your starting country, then list your exact itinerary in the additional information box below. State all ports where you will be exiting the ship, any activities and for how long. You do not need to complete a separate page for each country.

3. **Multiple destinations in one Country** (without leaving the country)-Identify the starting city/region and then list the other cities in order with the number of days and activities in the Additional Information box below.

Country #1: _____
Region, i.e. State/Province etc. _____
City/ Town or Rural Site _____
Days in this Country/Location _____
Cruise Y/N Ports: _____

Country #2 _____
Region, i.e. State/Province etc. _____
City/ Town or Rural Site _____
Days in this Country/Location _____
Cruise Y/N Ports: _____

Country #3 _____
Region, i.e. State/Province etc. _____
City/ Town or Rural Site _____
Days in this Country/Location _____
Cruise Y/N Ports: _____

PURPOSE OF TRAVEL: (check one)

Business _____ Vacation _____ Field Work _____ Teacher _____
Missionary _____ Climbing _____ Diving _____ Volunteer _____
Foreign study _____ Other: _____

ACCOMMODATIONS: (check choices)

Hotel ____ Resort ____ Private home ____ Safari ____ Camp _____
Youth hostel ____ Rented foreign home ____ Other _____

If known:

Date of arrival into malaria area: _____

Date leaving malaria area: _____

If in the Jungle, number or days _____ If high altitude (above
6000 feet, do not include air travel) # of days quick ascent _____

Additional Information relating to itinerary : For cruise ship itineraries, multiple destinations in one country or specific trip information you feel may be important. **NOTE:** If you are traveling to Panama please provide information as to which side of the country you are visiting. Malarial prophylaxis recommendations differ for the west (by Costa Rica) or east (by Columbia).

Vaccinations:

Have you ever been clinically diagnosed with Hepatitis A or B? Y/N

If yes, please explain: _____

Will you be in contact with blood or body fluids during your visit (i.e. health care workers, etc.)? _____

Please provide date of previous vaccination if known:

Hepatitis A #1 _____ Hepatitis A #2 _____

Hepatitis B #1 _____ Hep B # 2 _____ Hep B #3 _____

MMR _____ meningococcal _____ polio _____

Have you received an adult booster shot after the age of 17? _____

Tetanus (dT) _____ Have you received a booster shot as an adult in the last 10 years? Y/N Date _____

Typhoid _____ If yes, oral or shot _____

Have you ever had the chickenpox or received the Varicella vaccine? _____

Yellow Fever _____

Rabies _____ Japanese Encephalitis _____

Pneumonia _____ Flu Shot _____

Have you ever had any reactions due to a vaccine? Y/N

If so state reaction and type of vaccine _____

Please provide us with any other information that you feel may be important to us. _____

Please submit questionnaire by fax to 707 823-3851. Include credit card information here: # _____ Exp _____

OR mail to: 1131 Gravenstein Highway South, Sebastopol, CA 95472. Include a check made out to Erika Steffe MD (please see fee schedule under travel consultation via website questionnaire for cost).

We will send you a letter within 5 working days delineating what is required or recommended for your upcoming trip.

(please circle and provide contact information as needed) :

Mail Y/N (we will mail to address provided on the first page)

Fax Y/N please provide #(_____) _____

Email Y/N email address: _____