GATEWAY PHARMACY

# Travel History Screening Form

Name: _____ DOB: _____ Marital Status: _____Sex: (circle): M F

Phone: _____ Alt. Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Who is your primary care physician? _____ Telephone: _____

Employer: _____ Primary Insurance: _____

Does your health insurance cover:
Health care overseas? ☐ Yes ☐ No ☐ Not sure
Medical evaluation? ☐ Yes ☐ No ☐ Not sure

## Travel Plans

Purpose of trip (check all that apply): ☐ Vacation ☐ Education/Research ☐ Visit family/friends
☐ Missionary/volunteer/humanitarian relief ☐ Work (urban, office-based, or conference)
☐ Work (rural, outdoors, or in local community) ☐ Other: _____

Planned activities: _____

Will you be: Yes No

☐ ☐ Visiting ONLY urban areas? If no, explain: _____
☐ ☐ Visiting primitive or remote?
☐ ☐ Ascending to high altitudes?
☐ ☐ Working with potential exposure to bodily fluids (e.g., medical or dental work)?
☐ ☐ Working with exposure to animals?
☐ ☐ Potentially having new sexual partners?

| Countries and Cities (in order of visit) | Arrival Date | Departure Date |
|---|---|---|
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Accommodations (check all that apply):
☐ Resorts or Large Hotels ☐ Small Hotels ☐ Cruise Ship ☐ Private Home ☐ Camping
☐ Dormitory ☐ Other (specify)_____

Have you ever traveled outside the United States before? ☐ Yes ☐ No

If yes, when and where? _____

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Medical Conditions (ex: heart disease, cancer, arthritis, diabetes, high blood pressure, psychiatric illness)

_____

Surgical History: _____

Allergies (include medications, food such as eggs, environmental allergies such as ragweed):

_____

Intolerance or other reactions (side effects from previous medications (ex: nausea, constipation, sleepiness, dizziness, stomach upset, etc.): _____

_____

**Vaccination History**

Were you born in the United States? ☐ Yes ☐ No If no, where? _____

Have you received the following immunizations?

| | | | |
|---|---|---|---|
| COVID-19 | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Hepatitis A | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Hepatitis B | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| HPV | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Influenza (flu) | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Japanese Encephalitis | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Meningococcal Meningitis | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Measles/Mumps/Rubella | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Pneumococcal | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Polio | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Tetanus | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Typhoid | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Varicella | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Yellow Fever | ☐ Yes When? _____ | ☐ No | ☐ Not sure |
| Zoster (shingles) | ☐ Yes When? _____ | ☐ No | ☐ Not sure |

Other: _____

Have you ever had an adverse reaction to an immunization? ☐ Yes ☐ No

Explain: _____

_____

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## Medication History

Are you currently using corticosteroids, receiving cancer treatment, or other immunosuppressive therapy? ☐ Yes ☐ No

Nonprescription products: List all over-the-counter, herbal, vitamin, supplements, etc.

| Medications | Reason for Use/Medical Condition |
|---|---|
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| | |

Prescription Medications: List all current prescription medications and condition treated (include birth control pills):

| Prescription Medications | Reason for Use/Medical Condition |
|---|---|
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**Women Only**

Are you pregnant now, or do you suspect that you might be pregnant? ☐ Yes ☐ No
Do you have plans to get pregnant in the next 6 months? ☐ Yes ☐ No
Date of you last menstrual period: _____

**Questions/Concerns:**

List any additional questions or concerns you have about your travel:

_____
_____
_____