

Patients Name



## CHI Health Quick Care/Hy-Vee Pharmacy

Risk Assessment for Travelers

1000 S. 178<sup>th</sup> Street, Omaha, NE 68130

Pharmacy 402-334-4922

Clinic 402-717-0720

### Instructions

Travel Recommendations and prescriptions will be based on the information provided by the traveler. Providing accurate and complete information will result in the prevention of illness and cost effective travel recommendations.

**Please make sure this form is returned within 24 hours of your visit along with a copy of your medical and prescription insurance cards (front and back) as well as your immunization history.**

### Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Gender: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### Medical History

Please list any medical, and psychiatric history (past and current), any medications, or conditions that may suppress the immune system (e.g. steroids, chemotherapy, radiation therapy, cancers, HIV/AIDS): \_\_\_\_\_

Please list any current medications, and medications taken in the last 3 months including Over the Counter medications and herbs as well as birth control methods

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Allergies (especially those in vaccinations: eggs, thimersol, latex, yeast, mercury) or those in medications frequently prescribed when traveling (sulfa, quinines, tetracyclines):

\_\_\_\_\_

Pregnant OR breast-feeding, Date of Last menstrual period:

\_\_\_\_\_

Any planned surgery, or other medical care required during travel:

\_\_\_\_\_

**Medical Conditions (Please circle all that apply)**

- Anemia      Asthma      Blood Clots      Cancer      Depression      HIV/AIDS
- Diabetes      Epilepsy/Seizures      G6PD Deficiency      Heart Disease      Kidney Disease
- High Blood Pressure      Immune Deficiency      Liver Disease/Hepatitis      Lung Disease
- Psychiatric Disease      Sickle Cell Disease      Stroke      Thyroid/Endocrine

Deficits in Hearing/Vision/Ambulation

Please list any medications or conditions that may suppress the immune system (e.g. steroids, chemotherapy, radiation therapy, cancers, HIV/AIDS):

\_\_\_\_\_

**Risk Factors for DVT**

Have you had a blood clot?  
Y/N \_\_\_\_\_

Do you have a family  
history of blood clots?  
Y/N \_\_\_\_\_

Do you have a known  
clotting disorder? Y/N If  
yes, what is it? \_\_\_\_\_

Have you had a recent  
surgery or injury? Y/N \_\_\_\_\_

Do you use estrogen-  
containing birth control or  
hormone replacement  
therapy? Y/N \_\_\_\_\_

Do you have active  
cancer or undergoing  
chemotherapy? Y/N \_\_\_\_\_

Do you have limited  
mobility? Y/N \_\_\_\_\_

Are you over the age  
of 60? Y/N \_\_\_\_\_

Do you have a BMI > 25?  
Y/N \_\_\_\_\_

Suffered Altitude Illness in  
the past? Y/N \_\_\_\_\_

Suffered sea sickness  
in the past? Y/N \_\_\_\_\_

Jet lag? Y/N \_\_\_\_\_

Traveler's Diarrhea?  
Y/N \_\_\_\_\_

Adapted from: [http://www.cdc.gov/ncbddd/dvt/documents/DVT-Factsheet\\_Final1210.pdf](http://www.cdc.gov/ncbddd/dvt/documents/DVT-Factsheet_Final1210.pdf) 2012

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### Itinerary

Is this your first trip  
abroad? Y/N \_\_\_\_\_

Dates of Travel? \_\_\_\_\_

Purpose of trip (e.g.  
school/study, pleasure,  
business, mission/relief) \_\_\_\_\_

Country and Region	Arrival Date	Departure Date	*Mode of Transportation	Urban/Rural	**Accommodations	***Activities

\* Modes of transportation: Plane, train, auto, ship, bike

\*\* Types of accommodations: Indoor, air conditioning, screens, tents, open air

\*\*\* Activities: Hiking, climbing, scuba diving, site seeing, working, night life: including sexual activity potential new partners

Mission Or Work:  
Exposure to blood, body  
fluids: \_\_\_\_\_

Exposure to animals,  
farm or wild (please  
specify type of animal) \_\_\_\_\_

Adapted from: CDC 2012, The Yellow Book: Chapter 2 Pre-travel Consultation

<http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-2-the-pre-travel-consultation/the-pre-travel-consultation.htm>

I acknowledge that the above information is accurate to the best of my ability.

\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Date

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**Immunizations**

Please provide immunization records from your Primary Care Physician or fill out the immunization form below.

Hepatitis A: \_\_\_\_\_ / \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ / \_\_\_\_\_

Meningococcal Meningitis: \_\_\_\_\_ MMR: \_\_\_\_\_

Polio Series: \_\_\_\_\_ Adult Polio Booster: \_\_\_\_\_

Tetanus/Tdap: \_\_\_\_\_ Typhoid: \_\_\_\_\_

Influenza: \_\_\_\_\_

Other (s): \_\_\_\_\_

Yellow Fever \*: \_\_\_\_\_