Patients Name

CHI Health Quick Care/Hy-Vee Pharmacy

Risk Assessment for Travelers

1000 S. 178th 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

Patients Name

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): _____

Patients Name

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 2012

Patients Name

Itinerary

Is this your first trip abroad? Y/N _____ Dates of Travel? _____

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

Country	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 potentional 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

Patients Name

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 *: _____