

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

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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 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	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 animals,
Exposure to blood, body fluids: _____ 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 *: _____