LAST NAME, FIRST NAME		TODAY'S DATE

Lynn Oaks Compounding Pharmacy

TRAVEL HEALTH SERVICE

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	
Birth date: / /	E-Mail Address:	Age:	Sex: ☐ M ☐ F
Street address:	Home phone no: ( )	Work phone no.: ( )	
City:	State:	Zip Code:	

TRIP SPECIFICS

Purpose of Trip: ☐ Business ☐ Visiting family or friends ☐ Pleasure ☐ Other (if so, what is purpose):

Departure Date:	Return Date:	Have you traveled outside the US before: ☐ Yes ☐ No If yes, where and when?

Countries AND cities visiting (in order of visits)	Arrival Date	Departure Date

Will you be:	Yes	No	Will you be:	Yes	No
Visiting ONLY major cities?	☐	☐	Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains?	☐	☐
Staying ONLY in hotels?	☐	☐	Working in the medical or dental field with exposure to blood or other body fluids?	☐	☐
Visiting friends and family?	☐	☐	Potentially having sexual contact with new partners?	☐	☐
Exposed to animals?	☐	☐		☐	☐

MEDICAL HISTORY

Allergies:_____

_____

☐ No known drug allergies
☐ No known food allergies

Have you ever had an allergic reaction to any of the following? (check all that apply)
☐ Eggs
☐ Sula drugs (e.g.
☐ Antibiotics (e.g. Penicillin, Neomycin)
☐ Thimerosal

☐ Chrysanthemums
☐ Quinines
☐ Pyrimethamine
☐ Tetracyclines
☐ Other:

Immunization History
Were you born in the United States? ☐ Yes ☐ No If no, where?
Have you completed the following immunizations? (Please bring your vaccination records)

	Yes	If yes, when?	No	Not Sure
Influenza	☐		☐	☐
Hepatitis A	☐		☐	☐
Hepatitis B	☐		☐	☐
Meningococcal Meningitis	☐		☐	☐
MMR (Measles, Mumps, Rubella)	☐		☐	☐
Polio Series	☐		☐	☐
Tetanus, diphtheria, pertussis	☐		☐	☐
Pneumococcal	☐		☐	☐
Typhoid	☐		☐	☐
Yellow Fever	☐		☐	☐

Past AND Current Medical Conditions:	All Current Medications (Prescription, Nonprescription, Herbals, and Vitamins):

For Women Only:	When was your last normal menstrual period?
Are you or could you possibly be pregnant? ☐ Yes ☐ No	Are you breastfeeding an infant? ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN

Name:	Phone:	Fax
Address:		

PRINT FORM CLEAR FORM