Kusler's Compounding Pharmacy
Snohomish, WA

(360) 568-1297
www.kuslerspharmacy.net

# Travel Medical History Questionnaire (rev. 2013)

**Please bring your vaccination records and travel Itinerary to your appointment**

| | | |
|---|---|---|
| Name: | Phone: | Date: |
| Address: | E-Mail: | |
| □ M □ F | Date of Birth: | Age: |
| Physician's name: | Physician's Phone: | |
| Physician's address: | | |

| | | |
|---|---|---|
| Have you previously traveled to a developing country? | □ Yes | □ No |
| Are you traveling alone? | □ Yes | □ No |
| If no, name and age of other travelers: | | |

| | |
|---|---|
| Departure date: | Return date: |
| Please list, in order, all specific areas you plan to visit and the length of stay | |
| 1) | 3) |
| 2) | 4) |

| Trip Purpose: check all that apply | Accomodations: check all that apply |
|---|---|
| □ Business | □ Hotel 4 or 5 star |
| □ Vacation | □ Hotel 2 or 3 star |
| □ Study | □ Hostel |
| □ Missionary | □ Private home |
| □ Visiting friends or relatives | □ Camping |
| □ Safari | □ Safari |
| □ Cruise | □ Staying with locals |
| □ Long stay | □ Long-stay apartment |
| □ Volunteer or humanitarian work | □ Cruise ship |

| Trip Activities: check all that apply |
|---|
| □ Air travel |
| □ Public transportation ie. Bus, train |
| □ Biking |
| □ Rental car |
| □ Water sports ie. Swimming, boating |
| □ Scuba or snorkeling |
| □ Climbing or hiking |
| □ Visiting schools, hospitals, orphanages |
| □ Health care worker |
| □ Contact with animals |

**Please return completed form and a copy of your prescription insurance card to Kusler's Compounding Pharmacy fax (360) 243-3167. You will be contacted to schedule an appointment. Thank You!**

## Allergies

| | | | |
|---|---|---|---|
| Medication allergy? | □ Yes | □ No | Which ones? |
| Vaccine allergy? | □ Yes | □ No | Which ones? |
| Food allergy? | □ Yes | □ No | Which ones? |

| | | | |
|---|---|---|---|
| Environmental allergies ie. Hayfever, bee stings? | □ Yes | □ No | Explain: |
| Have you had an adverse reaction to an anti-malarial medicine? | □ Yes | □ No | Explain: |
| Other allergies? | | | |

## Women Only

| | | | |
|---|---|---|---|
| Date of last period? | Are you pregnant? | □ Yes - Due date: | □ No |
| Are you able to become pregnant? | □ Yes | □ No | |
| What is your method of birth control? | | | |

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| **Name:** | **Date:** |
|---|---|

**Immunization History**

| | | | |
|---|---|---|---|
| Do you have a written record of your vaccinations? | □ Yes | □ No | |
| Have you had any serious reactions to any vaccines? | □ Yes | □ No | |
| Have you been vaccinated in the past 4 weeks? | □ Yes | □ No | Which vaccines? |

| Vaccines | Date(s) Received | Never Had | Not Sure | Had Disease | Comments |
|---|---|---|---|---|---|
| Tetanus-Diphtheria Vaccine or Tdap | | | | | |
| Measles, Mumps, Rubella (2 doses) | | | | | |
| Polio (childhood series) | | | | | |
| Polio (adult booster) | | | | | |
| Chicken pox or Varicella (2 doses) | | | | | |
| Meningitis (Menomune or Menactra) | | | | | |
| Pneumonia | | | | | |
| Influenza (flu) | | | | | |
| Hepatitis A (2 doses) | | | | | |
| Hepatitis B (3 doses) | | | | | |
| Typhoid (□ oral or □ injectable) | | | | | |
| Yellow Fever | | | | | |
| Japanese Encephalitis (2 doses) | | | | | |
| Rabies (3 doses) | | | | | |
| Other Vaccines: | | | | | |

**Medical History**

| | | | | | |
|---|---|---|---|---|---|
| Psychiatric problems | □ Yes | □ No | Seizures | □ Yes | □ No |
| Irregular heartbeat | □ Yes | □ No | Heart disease or surgery | □ Yes | □ No |
| Psoriasis | □ Yes | □ No | Immunity problems | □ Yes | □ No |
| Stomach problems | □ Yes | □ No | Immune suppression drugs | □ Yes | □ No |
| Respiratory problems | □ Yes | □ No | Other: | | |

Please explain any "yes" answers:

Have you had any surgeries? □ Yes □ No What kind?

**Please list all of your current medications**
**Include prescription, over-the-counter, supplements and eye drops**

| Name of medication | Reason for use | Name of medication | Reason for use |
|---|---|---|---|
| 1) | | 6) | |
| 2) | | 7) | |
| 3) | | 8) | |
| 4) | | 9) | |
| 5) | | 10) | |

**How did you hear about this service?**

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment / administration of vaccines. I understand that payment in full by cash or credit card is due at the time of the visit.

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**Traveler/Parent/Guardian signature:** **Date:**