East Shore District Health Department-Travel Section
688 East Main Street Branford, CT 06405 (203)481-4233

Pre-Travel Health Consultation and History Form

Personal Information: Please complete this section Date:

Traveler's Name:

Date of Birth_____ Male ☐ Female ☐

Address: _____
_____

Telephone: (home) _____ E-mail: _____
(work) _____ (cell) _____

Occupation:

Country of Birth: Citizenship:

Trip Information:

Date of Departure from home:_____ Return date/length of trip:_____
Have you traveled internationally in the past? ☐ Yes ☐ No Where? _____
Do you intend to travel frequently in the future? ☐ Yes ☐ No ☐ Maybe
Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:
1._____
2._____
3._____
4._____
5._____

Destination: Urban ☐ Rural ☐ Remote ☐ At High Altitude ☐ Beach ☐

Is this a fixed itinerary? Yes ☐ No ☐ Unsure ☐

Purpose of trip: (check all that apply)

Vacation	☐	Medical care	☐	Business	☐
Education	☐	Adoption	☐	Volunteer/Humanitarian	☐
Visiting Friends and/or Relatives	☐			Long-stay traveler	☐

Organized tour? Yes ☐ No ☐ Partly ☐
Explain: _____

Accommodations: Hotel ☐ Hostel ☐ Staying with locals/family/friends ☐
Rented House/Apt ☐ Camping ☐ Cruise Ship/Boat ☐

Will you be travelling alone? Yes ☐ No ☐
If no, Explain _____

Planned Activities: (check all that apply)

Air Travel	☐	Biking	☐	Hiking ☐	Snorkeling ☐ Swimming ☐
Rafting	☐	Boating	☐	Scuba ☐	Climbing/Trekking ☐
Contact with Animals	☐	Cave/spelunking	☐		Public Transport ☐ (bus, train, etc)
Visiting schools, hospitals or orphanages	☐			Health Care Worker ☐	Occupational exposure ☐

Other:_____

Have you obtained travel medical evacuation insurance? Yes ☐ No ☐

Health History:

Health Care Provider: Telephone:

Address:

Do you have any chronic health problems for which you take medication on a regular basis or see a health care provider?
Yes ☐ No ☐
If yes, please explain:_____
_____

Are you currently under the care of a physician for any health problem: Yes ☐ No ☐ If yes, explain:_____

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Health History, cont'd.:

Do you currently have or have a past history of:

- Antidepressant or psychiatric medication use Yes ☐ No ☐
- Depression, anxiety, panic attacks Yes ☐ No ☐
- Psoriasis (skin disease) Yes ☐ No ☐
- Seizures or convulsions Yes ☐ No ☐
- Cardiac conduction defect, have a pacemaker Yes ☐ No ☐
- Heart disease or surgery Yes ☐ No ☐
- Respiratory (lung) disease Yes ☐ No ☐
- Muscle or bone problems Yes ☐ No ☐
- Intestinal problems including heartburn or reflux Yes ☐ No ☐
- Immune disorder (chemotherapy, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment) Yes ☐ No ☐
- Live/work closely with anyone with immune disorder Yes ☐ No ☐
- Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome) Yes ☐ No ☐
- History of altitude illness Yes ☐ No ☐
- Surgery or hospitalization in past 3-5 years Yes ☐ No ☐
- Have you had any transfusions or blood products in the past 5 years? Yes ☐ No ☐
- Have you ever had Hepatitis (liver infection)? Yes ☐ No ☐
- Has your spleen been removed? Yes ☐ No ☐
- Do you drink alcohol regularly? Yes ☐ No ☐
- Do you smoke? Yes ☐ No ☐
- Have you ever had a TB test? Yes ☐ No ☐
- History of tendonitis / Achille's heel rupture Yes ☐ No ☐
- Other medical problem Yes ☐ No ☐

Please explain any "yes" answers:

_____

_____

Allergies:

- Medication(s) Yes ☐ No ☐ If yes, list:_____
- Reaction to vaccine Yes ☐ No ☐ If yes, list:_____
- **Egg** or other food allergies Yes ☐ No ☐ If yes, list:_____
- Environmental (pollens, dust, hay fever, etc.) Yes ☐ No ☐ If yes, list:_____
- Animals Yes ☐ No ☐ If yes, list:_____
- Bee stings Yes ☐ No ☐

Have you ever experienced anaphylaxis (severe allergic reaction)? Yes ☐ No ☐

Medications:

Please list **all** prescribed and over-the-counter medications and supplements you use:

Medication or supplement:	Reason for use:
1	
2	
3	
4	
5	

When was your last dental visit? _____

Women:

When was your last menstrual period?_____ Was it normal? Yes ☐ No ☐

Are you currently or are you trying to become pregnant? Yes ☐ No ☐

Any risk of an unplanned pregnancy? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

What form of contraception do you use? _____

Please tell us any additional information that you believe is important for us to know as you prepare for your current trip:

_____

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature _____ Relationship if minor _____ Date _____

Reviewed by: _____ RN/ NP/ PA/ MD Date_____