TRAVEL HEALTH QUESTIONNAIRE

Patient Information

Name:	DOB:	Birth Country:	Date:
Address:	City:	State:	Zip:
Phone: (Mobile/Land)	Email:		Gender:
Preferred Cub Pharmacy:			
Primary Care Physician:	Provider Location:		
Provider Phone:	Provider Fax:		

Medical Insurance Insurance Name: ID number: Group:

Pharmacy Insurance Insurance Name: ID number: BIN: PCN: Group:

Medical History

Allergies: Check all that apply

- ❑ Injectable medications
- ❑ Preservatives (sulfites)
- ❑ Thimerosal
- ❑ Eggs
- ❑ Insect sting
- ❑ Latex
- ❑ Yeast
- ❑ Neomycin, Polymyxin B, Streptomycin, or Gentamicin
- ❑ Polyethylene glycol (PEG)
- ❑ Gelatin
- ❑ Vaccine; if so, which:__________

List any additional allergies:

Medications: ____

Food: ____

Conditions: Check all relevant and add any additional as needed

- ❑ Allergies
- ❑ Anemia
- ❑ Anaphylaxis
- ❑ Blood clots
- ❑ Cancer
- ❑ Coagulation disorder
- ❑ Diabetes
- ❑ Eye problems
- ❑ G6PD deficiency
- ❑ Gout
- ❑ Guillain-Barre Syndrome
- ❑ Heart disease
- ❑ Hearing problems
- ❑ Hepatitis
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Irregular Heartbeat
- ❑ Immune deficiency
- ❑ Kidney disease
- ❑ Lung disease
- ❑ Mental Health Problems
- ❑ Nightmares
- ❑ Osteoporosis
- ❑ Pregnant or Breastfeeding
- ❑ Prostate Problems
- ❑ Psoriasis
- ❑ Rheumatoid Arthritis
- ❑ Seizure disorder
- ❑ Splenectomy
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thymus disease
- ❑ Thyroid problems
- ❑ Transplant
- ❑
- ❑
- ❑
- ❑
- ❑
- ❑

Have you had any recent surgeries? ❑ Yes ❑ No If yes, explain: ____

Have you had any recent hospitalizations? ❑ Yes ❑ No If yes, explain: ____

Medications: list all current prescription and over the counter medications

______________________ ______________________ ______________________

______________________ ______________________ ______________________

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Immunizations: Identify immunization history below or provide a copy of your immunization records

Have you received the routine following vaccinations?

Vaccine	Yes	No	Vaccine type
Cholera	❑ Yes When?___________________________	❑ No	
COVID	❑ Yes When?___________________________	❑ No	Vaccine type: __Monovalent __Bivalent
Dengue	❑ Yes When?___________________________	❑ No	
Hepatitis A	❑ Yes When?___________________________	❑ No	
Hepatitis B	❑ Yes When?___________________________	❑ No	
Haemophilus influenza type b	❑ Yes When?___________________________	❑ No	
Human papillomavirus	❑ Yes When?___________________________	❑ No	
Influenza	❑ Yes When?___________________________	❑ No	
Japanese encephalitis	❑ Yes When?___________________________	❑ No	
Measles, mumps, rubella	❑ Yes When?___________________________	❑ No	
Meningococcal	❑ Yes When?___________________________	❑ No	Vaccine type: ___MCV4 ___MenB
Pneumococcal	❑ Yes When?___________________________	❑ No	Vaccine type: ___PCV ___PPSV23
Polio	❑ Yes When?___________________________	❑ No	
Rabies	❑ Yes When?___________________________	❑ No	
Rotavirus	❑ Yes When?___________________________	❑ No	
Shingles	❑ Yes When?___________________________	❑ No	
Tetanus	❑ Yes When?___________________________	❑ No	Vaccine type: ___Td ___Tdap
Typhoid	❑ Yes When?___________________________	❑ No	Vaccine type: ___Oral ___Injection
Varicella	❑ Yes When?___________________________	❑ No	
Yellow fever	❑ Yes When?___________________________	❑ No	

Travel Information

About your trip: (check all that apply)

Reason for Travel:
- ❑ Vacation
- ❑ Business
- ❑ Education
- ❑ Visit friends or family
- ❑ Volunteer or humanitarian work
- ❑ Medical work
- ❑ Long stay
- ❑ Other:

Accommodations:
- ❑ Resort/large hotel
- ❑ Small hotel/B&B
- ❑ Hostel
- ❑ Private home
- ❑ Staying with locals
- ❑ Cruise ship
- ❑ Camping
- ❑ Other:

Trip Activities:
- ❑ Ascending to high altitudes
- ❑ Anticipate close exposure to animals
- ❑ Visiting friends or relatives
- ❑ Receive medical care or dental work
- ❑ Diving
- ❑ Water activities
- ❑ Travel to rural areas
- ❑ Other:

Have you previously traveled to a developing country? ❑ Yes ❑ No

Have you previously received any medications related to travel? ❑ Yes ❑ No If yes, which:

Itinerary

List all cities and countries in order of travel:

____

____

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List the dates of travel for each location:

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By turning this completed form over to Cub Pharmacy, I attest to my understanding that medication, vaccination, and other health related recommendations will be made based on the completeness and accuracy of the information I have provided.