place label here
Name:
UIN:
Date:

TRAVEL CONSULT

Consult date:____________________________

1. Destinations: (be specific i.e., countries, states or provinces)____

2. Travel Plans: Departure date C-U_________________ From USA_______________________
   Return to USA_____________________ Total length of stay_________________

3. Travel Itinerary Plans: (Check appropriate boxes)
   - ☐ Hiking in rural areas
   - ☐ Working with animals
   - ☐ U of I Business (hotels)
   - ☐ Resort
   - ☐ Swimming in local streams/lakes
   - ☐ Working in health related field
   - ☐ Group travel (________________________)
   - ☐ ______________________________

4. Have you traveled internationally before? ☐ Yes ☐ No
   If traveled before internationally, did you get ill? ☐ Yes ☐ No
   If yes, what ____
   Have you been seen by MHC for previous travel? ☐ Yes ☐ No
   Is your itinerary similar to previous travel? ☐ Yes ☐ No
   If not, how is it different?____

5. List all health problems (i.e., involving blood pressure, diabetes, skin, ears, eyes, lungs, heart, liver, kidney, gastrointestinal, musculoskeletal, psychiatric, G6PD deficiency, etc.)______________________________

6. List all medications you are currently taking regularly or intermittently:____________________________

7. List other medications you anticipate needing before or during the trip and reasons for taking:_______________

8. List any medication or vaccine allergies:____

9. Will you be traveling in an area where medical treatment is available within 24 hours?___________________

10. Special concerns about travel?_______ If so, please specify:____

11. Have you read the CDC literature for travel to your destination? ☐ Yes ☐ No

FEMALES ONLY

Date of last normal menstrual period____________

1. Are you pregnant? ☐ Yes ☐ No
2. Do you plan to become pregnant during your travel or up to 3 months after travel? ☐ Yes ☐ No
3. Are you a nursing mother? ☐ Yes ☐ No
4. Are you on a hormonal contraceptive? ☐ Yes ☐ No
   If yes, circle: BCP patch ring Depo-Provera

Reviewed by:____MD / RN