

Marble Falls Minor Emergency / Hill Country Urgent Care 1

Travel Questionnaire

Marble Falls Minor Emergency Center / Hill Country Urgent care does not bill Medicare or other insurance carriers for Travel Medicine consultations or Immunizations related to travel. Travelers are responsible for all fees due at time of service.

PERSONAL DATA (PLEASE PRINT CLEARLY)

Last Name First Name Middle Initial

DOB _____ AGE _____ SEX M F

PHONE # _____

Home Office Cell

E-mail ADDRESS _____

OCCUPATION: _____

PRIMARY CARE PHYSICIAN _____ PHONE: _____

ADDRESS LOCATION: _____

ADDITIONAL FAMILY MEMBERS TRAVELING WITH YOU? Circle none 1 2 3 4 5 6

Age	Name	Sex M / F

May we send your primary care physician a copy of your immunization record? YES NO

Travel Itinerary

PLEASE LIST THE COUNTRIES YOU ARE TRAVELING TO IN ORDER APPROXIMATE LENGTH OF STAY IN EACH COUNTRY

_____ _____

_____ _____

_____ _____

DEPARTURE DATE _____ RETURN DATE _____

REASON FOR TRAVEL TOURIST BUSINESS STUDENT OTHER _____

ACCOMODATIONS HOTEL YOUTH HOSTEL FAMILY/HOME CRUISE CAMPING OTHER _____

Do you plan to visit only tourist areas or major cities ? Yes No

Do you plan to visit rural areas? Yes No

Do you plan to visit rural areas during evening or nighttime hours? Yes No

Do you plan to go hiking or backpacking? Yes No

Do you plan to go bicycling? Yes No

Do you plan to go swimming? Yes No

If yes, Chlorinated Pool Fresh Water Lake or Stream Ocean

Do you plan to travel or to climb to high altitudes? Yes No

Do you plan to scuba dive? Yes No

If yes. Are you certified? Yes No

When is air travel scheduled after last dive? _____

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Travel Questionnaire

Past Medical History Pertinent to Travel

Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Do you have high blood pressure or take high blood pressure medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have lung disease, asthma, chronic bronchitis, or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy (x-ray therapy). HIV/AIDS, or other immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Are you prone to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Have you ever had headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fainted from an injection or from having your blood drawn?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Do you have an active nerve condition? Do you have a history of Guillian-Barre Syndrome or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination? If yes, please describe: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Do you have a history of depression or psychiatric disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have tuberculosis? Have you ever tested positive for tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Do you have Diabetes? If yes, do you take insulin? Yes No	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Are you allergic to any drug, medication, vaccine, or vaccine component, such as penicillin, thimerosal, formalin, sorbitol, albumin, animal serum? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are you allergic to? _____ _____ _____ _____			Are you currently taking any medications including oral contraceptives and blood pressure medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list : _____ _____ _____ _____		

PREVIOUS IMMUNIZATIONS: Please indicate date (year) you received your last immunization for:

Chicken Pox	Immune Globulin	Polio	Yellow Fever
Flu	Japanese Encephalitis	Pneumonia	
Hepatitis A	Measles, Mumps, Rubella	Rabies	
Hepatitis B	Meningitis	Tetanus/Diphtheria	
Have you ever taken malaria pills? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you have any side-effects?			
What malaria pill did you take?			

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Travel Questionnaire

QUESTIONS FOR WOMEN

Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you breastfeeding (nursing) now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you plan to become pregnant within the next three months	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

IMMUNIZATION RECORD

Did you bring your immunization record with you? If not, we will provide one for you. Always bring this record with you for clinic visits. Make sure all your immunizations are recorded.

The above information is accurate to my best recollection. Marble Falls Minor Emergency Center / Hill Country Urgent care does not bill Medicare or other insurance carriers for Travel Medicine consultations or Immunizations related to travel. I am responsible for all fees due at time of service.

Traveler / Patient Name

Traveler / Patient Signature

Today's Date

Very Important: Please complete this form and return at least one week in advance of desired date of immunizations to make sure we have the immunizations that you will need in stock. Some immunizations may require prepayment. Many immunizations need to be completed up to six weeks prior to desired travel date. This form may be secure faxed to 830-798-1124 24 hours a day.

Please eat before your appointment.