Colorado Infectious Disease Associates
950 E. Harvard Ave., Ste. 140
Denver, CO 80210
303-777-0781

Please email or fax completed form back to:
Email: frontdesk@coloradoid.com
Fax: (303) 777-0786

Travel Health History Form

Today's Date: __ / __ / ____ (MM/DD/Year)

Last Name: First Name:

Address:

City: State: Zip:

Date of Birth: / / Gender: ☐ Male ☐ Female

Home Phone #: ( ) - Work Phone #: ( ) -

Cell Phone #: ( ) - E-mail address:

Emergency Contact: Contact's Phone Number: ( ) -

Primary Care Physician: Physician's Phone Number: ( ) -

Occupation: Employer's name:

Pharmacy's Name and Location: Pharmacy's Phone Number: ( ) -

Do you have a current passport or visa? ☐ Yes, a passport ☐ Yes, a visa ☐ No ☐ Don't Know

Travel Specifics:

1. Purpose of Trip: ☐ School Related Study/Work School/Company's Name: _____
   ☐ Pleasure ☐ Business ☐ Mission Trip: Name of Organization: _____ ☐ Other: _____
2. What will you be doing on this trip? _____
3. Does your program require completion of a medical form by a practitioner? ☐ Yes ☐ No
4. Are you currently enrolled in a health insurance plan that covers you while you are overseas?
   ☐ Unsure ☐ No ☐ Yes If yes, what insurance plan do you have? _____
5. Departure Date from the United States: _____ 6. Return Date to the United States: _____

Countries **AND** Cities to Be Visited **In Order** of Visits	Locale (city, rural, jungle, mountain, desert)	Arrival Date (mm/dd/year)	Departure Date (mm/dd/year)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

7. Have you traveled outside the United States before? ☐ Yes ☐ No
   If yes, where and when? _____
8. Will you be:

Yes	No	
☐	☐	Visiting only urban areas? If no, explain: _____
☐	☐	Staying only in hotels? If no explain: _____
☐	☐	Visiting friends and family?
☐	☐	Ascending to high altitudes (>7,000 feet or 2,300 meters) in the mountains?
☐	☐	Working in a medical or dental field with exposure to blood/other body fluids?
☐	☐	Working with exposure to animals?
☐	☐	Potentially having sexual contact with new partners?

Immunizations:

1. Were you born in the United States? ☐ Yes ☐ No If no, where: _____
2. Have you completed the following immunizations?

Hepatitis A (2 doses).	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Hepatitis B (3 doses)	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Influenza (current year)	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Japanese Encephalitis	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Meningococcal Meningitis	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
MMR (Measles, Mumps, Rubella) . . .	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Pneumonia	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Polio Series	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Polio Adult Booster	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____

Rabies Series	☐ Not Sure	☐ No	☐Yes	If yes, when: _____
Tetanus	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Typhoid (ORAL)	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Typhoid (INJECTABLE)	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Varicella (chicken pox).	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Yellow Fever	☐ Not Sure	☐ No	☐ Yes	If yes, when: _____
Zoster (shingles) IF OVER 50 YEARS OLD . .	☐ N/A	☐ No	☐ Yes	If yes, when: _____
Human Papillomavirus (Gardasil) (9 to 26 y/o). .	☐ N/A	☐ No	☐ Yes	If yes, when: _____

COVID Vaccine Dates (1st/2nd/boosters): _____

Medical History:

1. Are you taking steroids, receiving radiation therapy, or other immunosuppressive chemotherapy?
   ☐ Yes ☐ No If yes, what? _____

2. Please list your current prescription medications and the medical conditions being treated (include birth control pills)

Current Prescription Medications	Condition or Reason for Use

3. Please list regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc)

Regularly Used Non-Prescription Medications	Condition or Reason for Use

4. Have you been told you have any of the following medical conditions (check all that apply)?

	Yes	No	Family History		Yes	No	Family History		Yes	No	Family History
Anemia	☐	☐	☐	Eye Problems	☐	☐	☐	Kidney Disease	☐	☐	☐
Arrythmia	☐	☐	☐	G6PD Deficiency	☐	☐	☐	Liver Disease/Hepatitis	☐	☐	☐
Asthma	☐	☐	☐	Gout	☐	☐	☐	Lung Disease	☐	☐	☐
Blood Clots	☐	☐	☐	Hearing Problems	☐	☐	☐	Prostate Problems	☐	☐	☐
Cancer	☐	☐	☐	Heart Disease	☐	☐	☐	Psoriasis/Skin Problems	☐	☐	☐
Depression	☐	☐	☐	High Blood Pressure	☐	☐	☐	Psychiatric Problems	☐	☐	☐
Diabetes	☐	☐	☐	High Cholesterol	☐	☐	☐	Sickle Cell Disease	☐	☐	☐
Ear infections	☐	☐	☐	Hormone Problems	☐	☐	☐	Stomach ulcers/problems	☐	☐	☐
Epilepsy/Seizure	☐	☐	☐	Immune system Deficiency	☐	☐	☐	Stroke	☐	☐	☐
								Thyroid	☐	☐	☐

Other: (please explain) _____

5. Do you smoke? ☐ **Yes** ☐ **No** 6. Weight_____

Allergies:

1. Have you had a reaction to any of the following? (please check all that apply)
   ☐ No Known Drug Allergies
   ☐ Eggs ☐ Sulfa Drugs (e.g., Bactrim, Septra) ☐ Chrysanthemums
   ☐ Pyrimethamine ☐ Antibiotics (e.g., Neomycin, Streptomycin) ☐ Thimerosal (preservative in contact lens solution)
   ☐ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], or Primaquine)
   ☐ Tetracyclines (Doxycycline, Minocin, Minocycline, Acromycin, Sumycin)
   ☐ Other: Please specify _____
2. Do you have any food or drug allergies not listed above? If so, please list: _____

For Women Only:

a. When was your last menstrual period? _____
b. Are you, or could you possibly be, pregnant? ☐ Yes ☐No
c. Are you breast-feeding an infant? ☐ Yes ☐ No

Questions or Concerns – [for patients who have scheduled a FULL CONSULTATION only]:

1) Do you have any special concerns about your trip? [Please be specific]:_____

_____

Follow-up report of your consultation:

Do you authorize CIDA to send a follow up report to your physician after the consultation which will detail the education and immunizations received, and any applicable medication requests? Yes ☐No ☐

How did you hear about us?

☐ Apothecare Pharmacy
☐ Internet, if so what website: _____
☐ Referral from your physician – Dr: _____
☐ Word of Mouth, if so who: _____
☐ Marketing materials
☐ Other, please explain: _____

By signing below, I acknowledge that the information contained in this document is accurate and complete to the best of my knowledge. If medications will be prescribed to me, I understand that the clinic is operating under a drug therapy management protocol with the medical director, and I consent to be treated following this protocol.

X _____ _____

Signature Date