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**Travel Clinic Intake Form**

Traveler's Name \_\_\_\_\_  
Contact Phone \_\_\_\_\_  
DOB \_\_\_\_\_

Complete Travel Itinerary (Cities and Countries in order – and include any layovers):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Departure Date \_\_\_\_\_  
Duration of Travel \_\_\_\_\_

Major Medical Conditions of Traveler? \_\_\_\_\_

**\*Note: It is very important that you send ALL immunization records that you can gather along with this form. You may need to call the providers or offices where you received these, or even your school or employer if you ever supplied them with your records. If there are absolutely no records for your vaccines, please try to answer vaccine questions below:**

Has the traveler had the following vaccinations?

Hepatitis A: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ Meningococcal (meningitis): \_\_\_\_\_  
Tetanus: \_\_\_\_\_ Varicella: \_\_\_\_\_ MMR: \_\_\_\_\_  
Yellow Fever: \_\_\_\_\_ Typhoid: \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Has the patient been seen here previously? \_\_\_\_\_  
Who is the patient's primary care provider? \_\_\_\_\_

How did you hear about our travel clinic? \_\_\_\_\_

Statements to the client

**Full payment expected at the time of service.** Estimated charges will be given prior to the visit with the provider, but may change based on medical decision making in the visit. If you have insurance, we will bill them after your appointment. Please note most insurance companies do not cover travel vaccines.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date