



Physician Foundation
at California Pacific
Medical Center

A Sutter Health Affiliate
With You. For Life.

Travel Clinic Patient Health Questionnaire

Date ____/____/____

Name: _____ Date of Birth: ____/____/____ Sex: M F

Self Pay HMO PPO Name of Health Insurance and ID _____

Please provide the following information to be sure there are no contraindications to medications or vaccines:

Do you have a history of tendonitis? Yes No

Are you taking Coumadin or Warfarin? Yes No

Have you had any reactions to immunizations or travel medications in the past? Yes No

Are you currently being treated for cancer? Yes No

Do you have any history of Organ Transplant? Yes No

Do you have deficiency of the immune system? Yes No

Do you have a history of myasthenia gravis (chronic autoimmune neuromuscular disease)? Yes No

Are you under treatment for emotional problems? Yes No

Are you under treatment for epilepsy? Yes No

Do you have psoriasis? Yes No

Do you have any medical conditions such as diabetes, heart disease or lung disease? Yes No

If "yes," please explain: _____

Circle any of the following that you are allergic to: Eggs Sulfa Thimerosal Neomycin Streptomycin

Other allergies: _____

MEDICATIONS

List all medications you are currently taking (prescription or over-the-counter): _____

QUESTIONS FOR WOMEN

Are you pregnant or suspect you may be pregnant? LMP ____/____/____ Yes No

Are you trying to become pregnant? Yes No

Are you breastfeeding? Yes No

YOUR PERSONAL PHYSICIAN

Please provide the name of your regular physician, if any. _____

(Over, please.)

Date of Departure from U.S. ____/____/____

TRAVEL PLAN INFORMATION

Please list, in order, the countries to be visited and length of stay in each.

Country	No. of Days	Country	No. of Days
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT

Name _____ Relationship _____

Contact Phone Number _____

IMMUNIZATION HISTORY

Have you had or been immunized for the following conditions?

	Had the Disease	Immunized
Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (German measles)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A (2 doses)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (3 doses)	<input type="checkbox"/>	<input type="checkbox"/>

When was your last Tetanus/Diphtheria (Td) or Tdap Vaccine? _____

When was your last dose of Polio Vaccine? _____

When was your last dose of Yellow Fever Vaccine? _____

When was your last dose of Typhoid Vaccine? _____

When was your last dose of Meningococcal Vaccine? _____

When was your last dose of MMR Vaccine? _____

Thank you for choosing the Travel Clinic at California Pacific Medical Center.

We wish you a safe and enjoyable trip!