FAMILY CARE CENTERS
MEDICAL GROUP INC

## SECTION A — TRAVELER INFORMATION

First Name:_____ Last Name: _____

Date of Birth:___/___/___ Age:_____ Gender: ◯M ◯F Email:_____

Home Address:_____ Primary Phone: (____)_____

City:_____ State:_____ ZIP Code: _____

Doctor/Primary Care Provider:_____ Provider Phone: (____)_____

Provider Address:_____ City:_____ State:_____ ZIP Code:_____

Provider Email:_____ ☐ **I do not have a doctor/primary care provider.**

## SECTION B — MEDICAL HISTORY

**Allergies and Health Conditions**

List all chronic health problems, illnesses or allergies: (e.g. heart disease, high blood pressure, diabetes, etc.)

_____

_____

**Medications**

List all current medications you are taking: (prescription, over-the-counter, herbals and vitamins)

_____

_____

***Women only:*** Are you pregnant, trying to become pregnant or nursing? ◯Yes ◯No

## SECTION C — IMMUNIZATION HISTORY: Which immunizations have you had in the past?

| Vaccines | Yes/No | Date (If known) | Vaccines | Yes/No | Date (If known) |
|---|---|---|---|---|---|
| Influenza (Flu) | | | Typhoid (Oral or Injectable) | | |
| Tetanus/Diphtheria/Pertussis | | | Meningococcal | | |
| Measles/Mumps/Rubella | | | Hepatitis A | | |
| Pneumonia | | | Hepatitis B | | |
| Varicella (Chicken Pox) | | | Polio | | |
| Japanese Encephalitis | | | HPV | | |
| Rabies | | | Shingles | | |
| Yellow Fever | | | Other: | | |

## SECTION D — TRAVEL ITINERARY: Where are you going?

Departure Date:_____/_____/_____ Return Date:_____/_____/_____

| Countries To Be Visited (In Order) | City or Region | Length of Stay (Days) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Accommodations: ◯Hotel/Hostel ◯Private Home ◯Cruise ◯Camping ◯Other_____

Do you plan to visit rural areas (areas with animal/insect/mosquito-borne disease risk)? Yes◯ No◯

Do you plan to travel or to climb to high altitudes (more than 4,000 feet)? ◯Yes ◯No

Do you plan to go swimming? ◯Yes ◯No *If yes, where?* ◯Chlorinated Pool ◯Fresh Water Lake or Stream ◯Ocean

Do you suffer from motion sickness? ◯Yes ◯No Do you anticipate getting motion sickness on this trip? ◯ Yes ◯No

List any additional information on travel-related topics you would like to discuss:_____

_____

**Patient Signature**_____ **Date:**_____/_____/_____

# FAMILY CARE CENTERS HEALTH QUESTIONNAIRE

**PATIENT NAME**_____**DATE**_____

**REASON FOR VISIT**:_____

**FAMILY HISTORY:**

If any blood relative has suffered any of the following please circle the number and indicate which relative:

| | | | | | |
|---|---|---|---|---|---|
| 1) ☐ Epilepsy | ☐ 4) Glaucoma | ☐ 7) Hayfever | ☐ 10) Easy Bleeding | ☐ 13) Heart Disease | ☐ 16) High Cholesterol |
| 2) ☐ Migraine | ☐ 5) Diabetes | ☐ 8) Asthma | ☐ 11) Osteoporosis | ☐ 14) Stroke | ☐ 17) Alcoholism |
| 3) ☐ Mental Illness | ☐ 6) Thyroid | ☐ 9) Anemia | ☐ 12) Arthritis | ☐ 15) Hypertension | ☐ 18) Cancer of _____ |

**PERSONAL HISTORY: List Previous Hospital Admissions (not including pregnancies):**

| Year | Illness or Operation | Hospital | Year | Illness or Operation | Hospital |
|---|---|---|---|---|---|
| _____ | _____ | | _____ | _____ | |
| _____ | _____ | | _____ | _____ | |
| _____ | _____ | | _____ | _____ | |

**List All Current Medications and Dosage:**

**(include those you buy without a prescription)**

_____
_____
_____
_____
_____
_____

**List Allergies and Adverse Reactions**

_____
_____
_____
_____
_____
_____

**List Year of Last Vaccination:**

Tetanus / TD_____
Influenza (FLU)_____
Pneumonia_____
Hepatitis A_____
Hepatitis B _____
TB Skin Test_____

**(Please circle all answers Yes or NO. Have you ever had?)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | No Yes | Nervous Breakdown | No Yes | Kidney Disease | No Yes |
| Low Blood Pressure | No Yes | Anemia | No Yes | Gonorrhea or Syphilis | No Yes |
| Heart Disease | No Yes | Epilepsy | No Yes | Bladder Disease | No Yes |
| Diabetes | No Yes | Meningitis | No Yes | Scarlet Fever, Scarletina | No Yes |
| Tuberculosis | No Yes | Thyroid Disease | No Yes | Measles | No Yes |
| Influenza | No Yes | Hay Fever | No Yes | German Measles | No Yes |
| Pleuritis (Pleurisy) | No Yes | Asthma | No Yes | Rheumatic Fever | No Yes |
| Pneumonitis (Pneumonia) | No Yes | Hives or Eczema | No Yes | Chicken Pox | No Yes |
| Arthritis or Rheumatism | No Yes | Migraine Headaches | No Yes | Diphtheria | No Yes |
| Bursitis, Tendonitis | No Yes | AIDS/HIV | No Yes | Mumps | No Yes |
| Neuritis or Neuralgia | No Yes | Gallbladder Disease | No Yes | Small Pox | No Yes |
| Any Bone or Joint Disease | No Yes | Colitis or Other Bowel Disease | No Yes | Whooping Cough | No Yes |
| Sciatica, Back Pain, Lumbago | No Yes | Jaundice or Liver Disease | No Yes | | |
| Food, Chemical, Drug Poisoning | No Yes | Hemorrhoids or Rectal Disease | No Yes | | |
| Frequent Infections or Boils | No Yes | Cancer | No Yes Type of Cancer:_____ | | |

Have you ever had Blood or Plasma Transfusions? No Yes

Have you every been advised to have any surgical or medical treatment which has not been done? No Yes

Do You Drink Alcohol ? No Yes How Much? _____
Do You Smoke ? No Yes How many cigarettes or cigars per day? _____
Do You use Recreational Drugs? No Yes What kind ?_____

**INJURIES: Have you had any of the following**

Broken or cracked bones No Yes
Dislocations No Yes
Concussion, or head injury No Yes

**What is your weight?**: Now _____ One year ago _____ Maximum Weight Ever _____ When_____

**Date of your last Pap Smear**_____**Date of your last Mammogram**_____

**Physician Notes:**

_____