



**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:**

**List Allergies and Adverse Reactions**

**List Year of Last Vaccination:**

(include those you buy without a prescription)

_____	_____	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:**

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