Denver Public Health Travel Clinic

Patient Sticker

TRAVEL DATES: Date of Departure: _____ Date of Return: _____

List each Country in order:	**Length of Stay:**	**Urban:**	**Rural:**
Location #1: _____	_____	_____	_____
Location #2: _____	_____	_____	_____
Location #3: _____	_____	_____	_____
Location #4: _____	_____	_____	_____

Other_____

Provider Notes_____

PURPOSE OF TRAVEL (Circle all that apply):

Vacation	Student	Medical/Health	Scientific
Business	Volunteer	Mission Work	Other: _____

Provider Notes_____

ACCOMODATIONS AND ACTIVITIES (Circle all that apply):

Major hotels	Stay with my family	Cruise ship	Camping
Small hotels	Stay with local residents	Safari	Diving
Rented home	Hotel / Dorm	Trekking	Other: _____

Provider Notes_____

MEDICAL / TRAVEL HISTORY

Have you traveled previously outside the U.S? __Never ___Once ___Several Times ___Extensively

Please check YES or NO to the following questions:

GENERAL MEDICAL	YES	NO	*PROVIDER NOTES/PRECAUTION*
Do you have a medical condition that warrants maintenance medications or physician follow up? If yes, please list: Please List all medications you are currently taking:_____ _____			
Do you have a medical condition that is stable now, but that may recur while traveling?			
Do you have any stomach or bowel conditions such as diarrhea or constipation?			
Have you ever had hepatitis or yellow jaundice?			
Do you have a history of depression, anxiety, or any psychiatric problem?			
Do you have a problem with strange dreams and/or nightmares?			
Do you have problems with yeast infections when using antibiotics?			
Do you have psoriasis?			
Please list any medical condition we may not have asked about.			

MEDICATIONS	YES	NO	*PROVIDER NOTES/PRECAUTION*
Have you ever taken a medication to prevent malaria?			
Did you tolerate the malaria medication?			
If you took malaria medical, please list which one/s.			
What, if any side effects did you experience?			
Please list all prescriptions or over the counter medications you are currently taking or will be taking on this trip. Please include frequency and dosage.			

WOMEN ONLY	YES	NO	* PROVIDER NOTES/PRECAUTION*
Date of last menstrual period?			
Are you pregnant?			
Are you breastfeeding?			
Planning to become pregnant on this trip?			
Method of birth control?			

ADDITIONAL COMMENTS OR CONCERNS: