Swedish Medical Group Snoqualmie
37624 S.E. Fury St.
Snoqualmie, WA 98065
Phone: 425-888-2016
Fax: 206-320-5170
Monday-Friday, 8 a.m.-5 p.m.

Try to complete the travel form to the best of your ability, though it does ask a lot of information! If unknown, we will discuss together at your visit.

Travel medicine is about an overall assessment of your health needs and risks for your planned trip; we want you to have the best possible experience. Understanding your medical background and current concerns helps me partner together with you to review current recommendations and advice that works most effectively for you.

Marybeth Lambe MD FAAFP
International Society Travel Medicine
Infectious Disease Society of America
American Society of Tropical Medicine and Hygiene
International Society for Mountain Medicine
International Society for Infectious Diseases

TRAVEL VISIT (to be completed by traveler)

Name: _____ Today's Date: _____
Duration of Travel_____
Date you will be leaving the US: _____ Date you will arrive back in the US: _____
Date of Birth: _____ Male ___ Female___
During the first 5 years of your life, did you grow up in the United States? Yes___ No___
Did you have your routine childhood vaccinations? Yes__ No__
Do you have a record of your immunizations? Yes__ No__
Been in the military? You may have received multiple vaccinations while in the service.
_____

TRAVEL DRUG ALLERGIES
None of these ___
Do you have allergies to: __ Vaccines __ Mercury/Seafood/Eggs
__ Antibiotics __ gelatin, __Thimerosol __Other: _____
__ Insect bites __ Latex ___Neomycin ___Streptomycin
Medications (including non-prescription, supplements):
_____
_____
_____
_____

MEDICAL HISTORY:
Current Medical worries or concerns? No concerns__
_____
_____
_____
_____

Do you have of these medical risk factors?

None of these___
High blood pressure No__ Yes__
High cholesterol No__ Yes__
Abnormal heart rhythm No__ Yes__
History of blood clots No__ Yes__
Chest pain No__ Yes__
Heart murmur No__ Yes__
Fainting spells No__ Yes__
Diabetes No__ Yes__
Kidney Disease No__ Yes__

Heart murmur No__ Yes__
Asthma or emphysema No__ Yes__
Chronic respiratory infections No__ Yes__
Pulmonary embolism No__ Yes__
Leukemia or Cancer No__ Yes__
Spleen Removal No__ Yes__
HIV or AIDS No__ Yes__
Neurologic Diseases No__ Yes__
Emotional Disorder No__ Yes__
Psoriasis No__ Yes__
History of Thymus (NOT Thyroid) problems (eg. myasthenia gravis, DeGeorge Syndrome, thymoma) No__ Yes__
Been treated with immunosuppressive medication No__ Yes__

Double checking in case you need medication or special vaccines:

None of these_____
Do you have a prior history of:
(Malaria medicine impact)

- Anemia No__ Yes__
- Anxiety, Depression, frequent Nightmares No__ Yes__
- Sleep disturbance No__ Yes__
- Sun sensitivity No__ Yes__

- Gastrointestinal problems No__ Yes__
- Thyroid Disorder? No__ Yes__

(Live Vaccine impact)

- Immunosuppression (HIV, Cancer, Chemo, Steroids, Diabetes) No__ Yes__
- Any at home pregnant, with active cancer, or immunosuppressed? No__ Yes__
- Seizure history? No__ Yes__
- Hepatitis, liver disease? No__ Yes__
- Thymus disorder? No__ Yes__
- Myasthenia Gravis No__ Yes__

(Flight impact)

- Severe jetlag, insomnia, flight anxiety No__ Yes__
- Ear problems or recurrent infection? No__ Yes__
- History of blood clots in self or family No__ Yes__
- Good about staying hydrated No__ Yes__
- Concerns over excessive alcohol or other medication dependence? No__ Yes__

If going to Altitude, prior history of difficulty at altitude? No_Yes__

- Migraines No__ Yes__
- Asthma No__ Yes__
- Stroke or other neurologic event No__ Yes__

Are you pregnant, breast-feeding, or planning to become pregnant? No__ Yes__ NA__
Last menstrual period: _____ Type of contraception: _____

Prior Surgeries and Dates:

None__

_____
_____
_____
_____

PRIOR IMMUNIZATIONS/DATE (S):
Mostly unknown or no dates__

Yearly Influenza_____
Tetanus/ Diphtheria/ Pertussis (in the last 5-10 years?) _____
MMR #1_____ #2_____
Polio Dates_____ Oral or shot form___
Chicken Pox (Varicella) __#1_____#2_____ __
Hepatitis A #1_____ #2 _____ __
Hepatitis B #1 _____ #2_____ #3_____ __
Meningococcal _____
Age related vaccines:
Shingles (age over 50 years)
Pneumococcal (young children and elderly) __ Rotavirus (infants) __

Yellow Fever _____
Rabies _ #1____#2____#3_____
Typhoid _____
Japanese Encephalitis ____

Have you ever taken malaria medications in the past and, if you have, have you had adverse side effects to anti-malaria medication? __Yes __No

Some of the vaccines you will receive are live vaccines which mean they are minute doses of the real virus. If you live with, or closely associate with, someone who has reduced immunity you could transfer the virus to them. This may be an individual with AIDS or someone on immunosuppressive medication. Does this situation apply to you? _ Yes___ No___ Please explain___

Do you have any other health issues not mentioned above? **None__**
_____
_____
_____
_____

Insurance _____
Home Phone _____ Work Phone_____
Cell Phone_____
Emergency Contact_____ Relationship_____
E-mail address_____

ITINERARY: Destination(s) of Travel (include dates of arrival and departure for each country and rural travel expected for each List countries in order of itinerary
Dates: Country: City/State/Region: Elevation (if known)
_____ _____
_____
_____ _____
_____
_____ _____
_____
_____
_____

SPECIAL ACTIVITIES: _e.g. Climbing Biking? Water activities? Scuba Diving (Fresh Water Salt water?)
_____
ACCOMMODATIONS and Purpose: Urban/Rural__ Private home__ Cruise ship__
1st Class hotels__ Camping__ Religious Reasons__
Other hotels__ Tour group__ Adoption trip__ Mission Trip__ Prison visits__
Refugee Camps__

If this is a long trip with multiple stops, please read below:
If you are going on a long sojourn we would like to review your itinerary very carefully. Below, please list each country individually in the order you will be visiting each country. You can list them on a separate sheet of paper. Some shots depend upon which country you are coming from before entering another country.

If you are uncertain of spelling or city location and region:
Two helpful map sites are http://www.un.org/Depts/Cartographic/english/htmain.htm and http://www.lib.utexas.edu/maps/map_sites/country_sites.html

CRUISE SHIPS - Identify your starting country, and then list your exact itinerary. State all ports where you will be exiting the ship, any activities and for how long. You do not need to complete a separate page for each country.

MULTIPLE DESTINATIONS IN ONE COUNTRY (without leaving the country) - Identify the starting city/region and then list the other cities in order with the number of days and activities. You can list them on a separate sheet of paper.
These are the details we need to know:
Country and Region (if known) ___
Elevation__ (if known)
Proper order of destinations travelled
Number of days in location__
Urban? _ Rural? __ Airport Layover? __ Cruise ship port? __ Tour group__

Questions? Comments? Call or e-mail
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