Cedars Sinai

Travel History Form

Please complete this form and email it to csmntravel@cshs.org or fax it to 424-314-8755.

Name _____ Date of Birth _____ /_____ /_____

Primary Care Physician _____ Primary Care Physician Contact Number _____

Sex: ☐ M ☐ F Phone (____) _____ Country of Birth _____

Purpose of Trip: ☐ Business ☐ Pleasure ☐ School-related Study or Work

☐ Other: _____

Does your insurance cover: Health care overseas? ☐ Yes ☐ No ☐ Not sure

Medical evaluation? ☐ Yes ☐ No ☐ Not sure

Country AND Cities in Order of Visit (include return visits)	Arrival Date	Departure Date

Accommodations: (Check all that apply.)

☐ Resorts or large hotels
☐ Cruise ship
☐ Camp
☐ Youth hostel
☐ Small hotels
☐ Private home
☐ Dormitory
☐ Other (list): _____

Will you be:

- Visiting ONLY urban areas? ☐ Yes ☐ No
- Working with exposure to animals (e.g., veterinary work)? ☐ Yes ☐ No
- Doing any fresh water activities? ☐ Yes ☐ No
- Visiting friends and/or family? ☐ Yes ☐ No
- Providing aid/working with refugees? ☐ Yes ☐ No
- Working in the medical or dental field with exposure to blood? ☐ Yes ☐ No
- Ascending to high altitudes (greater than 8,000 feet, not including flying)? ☐ Yes ☐ No
- Potentially having sexual contact with new partners? ☐ Yes ☐ No

Have you had an allergic reaction to any of the following? (Check all that apply.)

☐ Antibiotics (tetracyclines or neomycin)
☐ Bee stings
☐ Chrysanthemums
☐ Soy
☐ Lactose
☐ Pyrimethamine
☐ Yeast
☐ Sulfa Drugs
☐ Thimerosal
☐ Eggs
☐ Other allergies: _____

(continues)

Travel History Form (continued)

Vaccination History

Were you born in the United States? ☐ Yes ☐ No If no, where? _____

Have you completed the following immunizations?

- Hepatitis A ☐ Yes ☐ No If yes, when? _____
- Hepatitis B ☐ Yes ☐ No If yes, when? _____
- Influenza ☐ Yes ☐ No If yes, when? _____
- Meningococcal ☐ Yes ☐ No If yes, when? _____
- MMR (measles, mumps, rubella) ☐ Yes ☐ No If yes, when? _____
- Polio ☐ Yes ☐ No If yes, when? _____
- Tetanus/diphtheria/pertussis ☐ Yes ☐ No If yes, when? _____
- Typhoid fever ☐ Yes ☐ No If yes, when? _____
- Yellow fever ☐ Yes ☐ No If yes, when? _____
- Japanese Encephalitis ☐ Yes ☐ No If yes, when? _____
- Pneumococcal ☐ Yes ☐ No If yes, when? _____
- Varicella ☐ Yes ☐ No If yes, when? _____

Have you ever had an adverse reaction to an immunization? ☐ Yes ☐ No

If yes, please explain: _____

_____

Health History

Medical Conditions (such as heart disease, stroke, cancer, arthritis, diabetes, psychiatric illness, HIV, lymphoma, thymus disorder, leukemia, organ transplant, Guillain-Barre, myasthenia gravis, etc.):

_____

_____

Medications

Are you currently using corticosteroids, receiving cancer treatment, or other immunosuppressive therapy?

☐ Yes ☐ No

Prescription and Nonprescription Medications	Reason for Use

For Women Only:

- When was your last normal menstrual period? _____
- Are you or could you possibly be pregnant? ☐ Yes ☐ No
- Are you breastfeeding an infant? ☐ Yes ☐ No
- Do you have plans to become pregnant in the next 3 months? ☐ Yes ☐ No

Questions/Concerns

List any additional questions or concerns you have about your travel: _____

_____