THE KROGER CO. FAMILY OF PHARMACIES

TRAVEL HISTORY FORM

Please complete this **prior to your appointment**. Please be as specific as possible. The information you provide will help the pharmacist prepare a personalized travel plan for you.

PATIENT INFORMATION

Name: ☐Male ☐Female Date of birth:

Address:

Home phone: Cell phone: Work phone:

Email:

What prescription insurance do you have (bring your insurance card to appointment):

BIN: PCN: ID: RxGrp: Pharmacy help desk phone #:

Do you have a current passport/visa? ☐Yes ☐No ☐Don't know

Primary care provider: Provider phone: Provider fax:

How did you hear about our service? ☐Doctor ☐Pharmacy ☐Friend/family ☐Online ☐Other:

TRAVEL SPECIFICS

Departure date from the US: Return date to the US:

List countries AND cities to be visited in order of visits	Arrival Date	Departure Date

Purpose of Trip: ☐School related study/work. What school?

☐Pleasure ☐Business ☐Visiting friends/family ☐Missionary ☐Other:

What will you be doing on this trip?

Have you traveled outside the United States before? ☐Yes ☐No

If yes, when and where?

Yes	No	
☐	☐	Will you be visiting **ONLY** major cities? If no, explain:
☐	☐	Will you be staying **ONLY** in hotels? If no, explain:
☐	☐	Will you be ascending to high altitude (>7000 ft. or 2300 meters) in the mountains?
☐	☐	Will you be working in the medical or dental field with exposure to blood or other body fluids?
☐	☐	Will you be working with exposure to animals?
☐	☐	Will you potentially have sexual contact with new partners?
☐	☐	Does your travel program or country require the completion of a medical form by a practitioner?
☐	☐	Are you currently enrolled in a health insurance plan that covers you while overseas?
☐	☐	Do you have medical evacuation insurance?

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ALLERGIES

☐No known DRUG allergies ☐No known FOOD allergies

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

☐Eggs
☐Sulfa drugs (e.g. Bactrim, Septra)
☐Antibiotics (e.g. neomycin, streptomycin)
☐Tetracyclines (e.g. doxycycline, minocycline)
☐Quinines (e.g. choloroquine [Aralen], mefloquine [Lariam], hydroxychloroquine [Plaquenil], Primaquine)
☐Thimerosal (preservatives)
☐Chrysanthemums
☐Pyrimethamine
☐Other:_____

Please list any past intolerances or adverse reactions to any vaccines AND/OR antimalarial medications:

MEDICAL HISTORY

Are you using steroids, receiving radiation or immunosuppressive therapy? ☐Yes ☐No

For women only: Last normal menstrual period: _____

Are you, or could you possibly be pregnant? ☐Yes ☐No

Are you breastfeeding an infant? ☐Yes ☐No

List your current prescription AND non-prescription medications or dietary supplements. Include drug name, dosage, and direction of use	Condition or reason for use

Have you been told that you have any of the following medical conditions (check all that appy)?

Yes	No	Family History		Yes	No	Family History	
☐	☐	☐	Anemia	☐	☐	☐	High blood pressure
☐	☐	☐	Asthma	☐	☐	☐	Hormone problems
☐	☐	☐	Blood clotting problems	☐	☐	☐	Immune system deficiency
☐	☐	☐	Cancer	☐	☐	☐	Kidney disease
☐	☐	☐	Depression	☐	☐	☐	Liver disease/hepatitis
☐	☐	☐	Diabetes	☐	☐	☐	Lung disease
☐	☐	☐	Ear infections (chronic or frequent)	☐	☐	☐	Prostate problems
☐	☐	☐	Epilepsy/seizure disorder	☐	☐	☐	Psoriasis/other skin problem
☐	☐	☐	Eye problems (except glasses/contacts)	☐	☐	☐	Sickle cell disease
☐	☐	☐	G6PD deficiency	☐	☐	☐	Stomach ulcer
☐	☐	☐	Gout	☐	☐	☐	Stroke
☐	☐	☐	Hearing problem	☐	☐	☐	Thyroid problems
☐	☐	☐	Heart disease	☐	☐	☐	Other:

Please list additional questions or concerns that you might have regarding your travel (i.e. jet lag, international voltage requirements, currency exchange, dealing with sickness, etc.)

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IMMUNIZATIONS

Were you born in the United States? ☐Yes ☐No. If no, country of birth? _____
Have you completed the following immunizations? (Please bring your vaccination record to the appointment)

Travel Related Vaccines	Date Administered	Comments/Notes
Hepatitis A	Dose 1: Dose 2:	
Hepatitis B	Dose 1: Dose 2: Dose 3:	
Hepatits A/B combination vaccine	Dose 1: Dose 2: Dose 3:	
Typhoid	Initial dose: Booster(s):	
Yellow fever	Initial dose: Booster(s):	
Japanese encephalitis	Dose 1: Dose 2:	
Rabies	Dose 1: Dose 2: Dose 3:	
Meningococcal meningitis	Initial dose: Booster(s):	
Influenza	Annual booster(s):	
Routine Vaccines	Date Administered	
Diphtheria, tetanus, pertussis (Tdap, Td)	Initial dose: Booster(s):	
Human papillomavirus (HPV)	Dose 1: Dose 2: Dose 3:	
Measles, mumps, rubella	Dose 1: Dose 2:	
Pneumococcal disease	Initial dose: Booster(s):	
Polio	Dose 1: Dose 2: Dose 3:	
Rotavirus	Dose 1: Dose 2: Dose 3:	
Varicella (chickenpox)	Dose 1: Dose 2:	
Herpes zoster (shingles)	Only 1 dose required:	
Other Vaccines	Date Administered	