



Travel Medicine Clinic

Family Health Center of Fort Myer
(Rader Army Health Clinic)



MEDICAL PREPARATION FOR INTERNATIONAL TRAVEL

Name		Sponsor's SSN (Last 4 only)		Daytime Phone	
Unit & Address		Age	Sex	Occupation	
		Place of Birth		Status <input type="checkbox"/> AD <input type="checkbox"/> DEP <input type="checkbox"/> RET <input type="checkbox"/> CIV <input type="checkbox"/> Other:	
Have you ever lived outside of the United States for longer than 6 months? No Yes If yes, where and when?					

TRAVEL PLANS

Date of Departure: _____ Date of Return: _____			Reason(s) for travel: <input type="checkbox"/> Tourism <input type="checkbox"/> TDY <input type="checkbox"/> PCS <input type="checkbox"/> Military deployment <input type="checkbox"/> Business (non-military) <input type="checkbox"/> Diplomatic/humanitarian mission <input type="checkbox"/> Visiting friends/relatives																														
ITINERARY (In order): <table border="1"> <thead> <tr> <th></th> <th>Country</th> <th>Cities/States</th> <th>Length of Stay</th> </tr> </thead> <tbody> <tr><td>1.</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>2.</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>3.</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>4.</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>5.</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>6.</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>				Country	Cities/States	Length of Stay	1.	_____	_____	_____	2.	_____	_____	_____	3.	_____	_____	_____	4.	_____	_____	_____	5.	_____	_____	_____	6.	_____	_____	_____	Locale(s): <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural <input type="checkbox"/> Jungle <input type="checkbox"/> Mountains <input type="checkbox"/> Beach		
	Country	Cities/States	Length of Stay																														
1.	_____	_____	_____																														
2.	_____	_____	_____																														
3.	_____	_____	_____																														
4.	_____	_____	_____																														
5.	_____	_____	_____																														
6.	_____	_____	_____																														
From what sources do you anticipate obtaining meals? <input type="checkbox"/> Restaurants <input type="checkbox"/> Street vendors <input type="checkbox"/> Family/friends <input type="checkbox"/> Self-prepared <input type="checkbox"/> Field rations			Special Activities: <input type="checkbox"/> Snow sports <input type="checkbox"/> Animal handling <input type="checkbox"/> Water sports <input type="checkbox"/> Mountaineering <input type="checkbox"/> Safari <input type="checkbox"/> Other:																														
What forms of contact with indigenous persons do you expect? <input type="checkbox"/> Meetings <input type="checkbox"/> Social events <input type="checkbox"/> Indoor crowds <input type="checkbox"/> Physical contact <input type="checkbox"/> Proximity to children			Accommodations: <input type="checkbox"/> Hotel <input type="checkbox"/> Private residence <input type="checkbox"/> Campsite <input type="checkbox"/> Hostel/dormitory <input type="checkbox"/> Cruise ship <input type="checkbox"/> Military base <input type="checkbox"/> Other:																														

PERTINENT MEDICAL HISTORY

Prior travel to developing countries: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where & when? _____	
Prior travel illness: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: _____	
Prior travel medications: <input type="checkbox"/> Malaria pills <input type="checkbox"/> Anti-diarrheals <input type="checkbox"/> Motion sickness pills <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other: _____	
Medical Conditions (past and current): Heart disease (incl. arrhythmias) Lung disease (incl. asthma) Diabetes High blood pressure Cancer Epilepsy (seizures) Hepatitis GI problems (incl. ulcers) Psychiatric Chickenpox Immune system disorder Ear/sinus problems Thyroid disease Deep venous thrombosis Measles Polio Hives/urticaria	Allergies: None Eggs Thimerosal Sulfa Penicillin Neomycin Polymyxin Sulfites Bee stings Aluminum Streptomycin Neomycin Amphotericin B Other: _____ Specify type of reaction: _____
Current Medications (prescription, OTC, herbals, and supplements): None As listed below (include doses): _____ _____ _____	Women's Health: Are you currently pregnant or trying? No Yes Are you currently breastfeeding? No Yes Do you have frequent yeast infections? No Yes Are you currently taking birth control pills? No Yes



STOP! Please complete this side of the form only. Bring this form along with all medical and immunization records to your appointment. One form must be completed for each traveler.