

TRAVEL - MED
09/06

ADULT TRAVEL CLINIC ASSESSMENT
PLEASE EXPEDITE

**Primary Care
Provider**

Complete for any Travel Clinic appointment or request

Member's Name:	Medical Record Number	Date	Time:
Member's Address:	Phone: (D)	Facility:	
DOB: _____ Age: _____	Gender: M F	Phone: (E)	PCP:

*****Departure Date:** _____ **Return Date:** _____ **Place of birth:** _____ **If not USA, how long in USA:** _____

ALL Destinations (cities, regions, countries)	Length of Stay	<input type="checkbox"/> Staying rural area/home/hotel	Purpose of visit
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

Purpose: pleasure, business, school, research, volunteer service

Special Exposures? Altitude, diving, white water rafting, jungle, hostile environment

Are you currently on any medications? If yes please list: _____
