NorthShore University HealthSystem

Travel Center

2150 Pfingsten Road Suite 3000
Glenview, IL 60026
847-657-5670 fax 847-657-1759

TRAVEL HEALTH HISTORY

Please be sure to answer all of the questions presented below as completely and accurately as possible and include all copies of all available immunization records. This information will be used in planning your travel health recommendations which will be prepared as soon as the information is received. An *incomplete* questionnaire may *delay* your recommendations and immunizations. All information is strictly confidential. Please print clearly. Attach additional sheets, if necessary.

Name_____Age_____Sex_____
Address_____
City_____ State _____Zip_____
Home Phone_____ Cell Phone _____
Date of Birth_____ Place of Birth_____
Weight (approximate)_____lbs. Social Security #_____-_____-_____
Marital Status: Please circle Single Married Widowed Divorced
Have you ever been a patient at our Travel Immunization Centers before? No Yes
If yes, Where? ___ Evanston ____ Glenbrook ____ When? _____

Employer: _____
_____

Are you a **NORTHSHORE** employee?_____
If yes, do you have **Aetna Insurance** through NorthShore? _____

1. PLANNED ITINERARY—in EXACT ORDER of travel:

Departure Date_____ Return Date (approximate)_____

Country (list cities)	Length of Stay	Any Rural Travel (circle)
1._____	_____	No Yes
2._____	_____	No Yes
3._____	_____	No Yes
4._____	_____	No Yes
5._____	_____	No Yes
6._____	_____	No Yes
7._____	_____	No Yes
8._____	_____	No Yes

Attach printed/detailed itineraries (e.g., from cruise line, travel agent etc.) if applicable.

2. ACCOMODATIONS: (Check all that apply.)

____Resort ____Cruise Ship ____Private Home ____Camp
____Dormitory ____Small hotels ____Youth Hostel Other_____

3. PURPOSE OF TRAVEL: (Check all that apply.)

____Business ____Teaching ____Biking/Hiking ____Volunteer Organization
____Vacation ____Diving ____Safari ____Foreign Study
____Climbing ____Missionary Other_____

4. MEDICAL HISTORY:

Do you have *ANY* ALLERGIES? (Latex, foods—especially eggs)? (circle) No Yes

If yes, please describe allergy and reaction:_____
_____

Have you ever had any of the following diseases? (Circle yes or no. If yes, give details and dates).

Measles, Mumps, or Rubella (indicate which one)	No	Yes	_____
Chicken Pox or "Shingles"	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Hepatitis/Liver Disease or impaired liver function	No	Yes	_____
Kidney Disease or kidney function problems	No	Yes	_____
Gastrointestinal problems (ulcer, ulceractive colitis, Crohns)	No	Yes	_____
Respiratory Disease (asthma etc.)	No	Yes	_____
Neurological Disorder including MS	No	Yes	_____
Seizure Disorder/Epilepsy	No	Yes	_____
Depression	No	Yes	_____
Psychiatric Disorder	No	Yes	_____
HIV or Immune Deficiency	No	Yes	_____
Cancer or Leukemia	No	Yes	_____
Hives	No	Yes	_____
Psoriasis (diagnosed by a physician)	No	Yes	_____
Blood or Plasma Transfusion	No	Yes	_____
Autoimmune problems (rheumatoid arthritis, systemic lupus erythematosus)	No	Yes	_____

5. CURRENT MEDICATIONS: Are you taking *any* medications? (Circle) No Yes

List all current medications and dosage schedules (include oral contraceptives and over-the-counter drugs):

_____ _____
_____ _____
_____ _____

6a. IMMUNE SYSTEM:** Have you ever received any of the following treatments?

Treatment	(Circle)	Reason	Date(s)
Radiation Therapy	No Yes	_____	
Cancer Chemotherapy	No Yes	_____	

Cortisone/Steroids or other medications that affect the immune system? No Yes
Indicate reason and the dosages, form(s) (pills, injection, inhaler, etc.) dates and duration of treatment:
_____
_____

b. Do you live (or work closely with) anyone who has AIDS, an AIDS-like condition, a suppressed immune system, or who is receiving any of the treatments listed above in "6a"? (Circle) No Yes

**(The purpose of these questions is to assist us in assessing any possible risk to you or your contacts from certain immunizations).

7a. PRIOR IMMUNIZATIONS: Indicate month/year of all doses received. Please respond for each and attach copies of all available immunization records.

_____Tetanus	_____ "Gamma" Globulin
_____Diphtheria	_____ Hepatitis A Vaccine
_____Measles	_____ Hepatitis B Vaccine
_____Mumps	_____Typhoid--Injected
_____Rubella	_____Typhoid--Oral
_____Polio series and booster(s)	_____Yellow Fever
_____Influenza (Flu shot)	_____Cholera
_____Pneumococcal (Pneumonia)	_____Rabies
_____Meningococcal (Meningitis)	_____Japanese Encephalitis
_____Varicella (chicken pox)	Other_____

b. Have you ever had an adverse reaction to any immunization?_____
_____
_____

8. WOMEN ONLY:
Are you pregnant now or do you suspect that you might be pregnant? (Circle) No Yes
Are you planning a pregnancy in the next six months? (Circle) No Yes
When was your last menstrual period? Date_____

9. PHYSICIAN INFORMATION: Who is you personal physician?
Name_____
Address_____ City_____
State_____ Zip_____ Phone_____

10: ADDITIONAL INFORMATION:
Please include any additional information that you think might assist us in preparing your travel health recommendations._____
_____
_____
_____

Please check to make sure that you have answered **ALL** of the questions.
Incomplete forms may delay processing.

Please sign below and return the completed form to initiate the preparation of your travel health recommendations and immunizations **(unsigned forms cannot be processed).**

_____ _____
Signature **Date**

Pharmacy Information: NAME_____
Phone number_____
Address _____

Notice and Acknowledgement

I acknowledge that I have received NorthShore's Notice of Health Information Practices.

_____ _____
Witness Date Patient's or Personal Representative Signature

_____
Personal Representative Relationship to Patient

Patient unable to sign. Reason: _____