

LABEL

Patient Travel Consultation

Departure date from U.S. _____

Patient Home Phone: _____

Patient Work Phone: _____

TRAVEL ITINERARY

Destination(s) (Separate urban or rural areas and regions of the country.)	Date of Arrival at destination	Departure date from destination	Length of Stay at each destination

MEDICAL HISTORY

Childhood Immunizations Up To Date Yes No Unknown

Medical Conditions:

- Hypertension
- Cardiovascular Disease
- Diabetes
- Epilepsy
- Other: _____

Current Medications or Treatments:

Allergies to Medication or Food:

Vaccinations or Medications for this Trip from Other Providers: