Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL

Travel Health Services Patient Information Form

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell phone_____ Email _____

How did you hear about us? _____ Age _____ Sex M / F

Occupation _____ Employer _____

Primary Care Physician_____ Address _____

Travel Departure Date _____ Return Date_____

Countries to be visited (in order)	Length of Stay

Reason for trip: ☐Business ☐Tourist ☐Student ☐Mission ☐Other _____

Are you planning to travel outside of urban areas? Yes No

Are you planning to go hiking, backpacking or swimming? Yes No

Are you planning to go scuba diving? Yes No

Accommodations: ☐Hotel ☐Youth Hostel ☐Private Home ☐Camping ☐Cruise ☐Local Home
☐ Other_____

Do you have:

Heart trouble/High Blood Pressure ..... Yes No
Lung Disease/Asthma ..... Yes No
Diabetes ..... Yes No
Skin Disease ..... Yes No
Mental Illness/Depression ..... Yes No
Seizure disorder/Epilepsy ..... Yes No
A bleeding disorder and/or take anticoagulants? ..... Yes No
A history of thymus condition/thymectomy? ..... Yes No
A history of an immune disorder, such as cancer or HIV? ..... Yes No
Myasthenia Gravis, or a problem with your thymus? ..... Yes No

Have you received any vaccine within the last 30 days (chickenpox/shingles/MMR)? Yes No

Have you ever had an adverse reaction to a shot? Describe_____ Yes No

Have you taken Prednisone, steroids, or chemotherapy drugs in the last 3 months? Yes No

Do you LIVE WITH someone who is taking Prednisone, steroids, or chemotherapy drugs? Yes No

Do you LIVE WITH someone who has cancer or HIV? Yes No

Do you plan to have medical/dental procedures overseas? Yes No

Do you take blood thinners? Yes No

CIRCLE any allergies you may have: eggs / latex / yeast / mercury(Thimerisal) / gelatin / bee stings

Medicine allergies (list)_____ other allergy(list)_____

Current medications: _____

_____

When was your last tetanus shot?_____

Women Only:

Are you pregnant or trying to get pregnant?	Yes	No
Are you breastfeeding?	Yes	No

Last Menstrual Period_____

PLEASE PRESENT A COPY OF YOUR IMMUNIZATION RECORDS

Consent for Services: I understand that, while remarkably safe, vaccines can, in rare instances, cause complications including death. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease.

I also understand that CVMC OHS does not file claims for nor accept any form of insurance payment for travel visits. I understand that my health insurance is a contract between me and my insurance company. I understand that CVMC OHS will not refund any difference between my insurance reimbursement and CVMC OHS charges.

I certify that the above information is correct

Print Name _____

Signature_____ Date_____

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