Travel Medicine Intake Form

Contact Information:
Name (first and last): ________________________ date of birth __ /__ /___ Phone________________ Email_________________

Other____

Itinerary Information

Type of travel *(please circle)* **Business Tourist Mission School Visiting family/friends Other________________**

Date of departure __/__/___ **Return date __/__/___**

Country: __________________ _____ **City/region ________________________**

Country: _______________________ **City/region ________________________**

Country: __________________ _____ **City/region ________________________**

Country: __________________ _____ **City/region ________________________**

High Altitude Travel
Are you traveling above 8, 000 ft.?

Yes No Unknown

Accommodations (*please circle all that apply)*

Hotel Lodges family/friends renting apt/condo Hostels Company Guest House Camping

Dormitory other: ____

Activities

____

____

Medical Information

Please let us know of any current and/or chronic medical conditions:

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Please tell us if you're taking medications

Medication	Dosage	Times per day

Allergies

Allergic to	Reactions

Do you have any specific concerns or requests regarding your upcoming travel? *(If yes please specify)* **Yes No**

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Note: Please do not email medical information. **