

Basil C. Fine, MD, PhD, DTM&H
Travel & Tropical Medicine, & Parasitology
 1153 Centre Street, Suite 5930, Boston, MA 02130-3446
 phone 617-524-2300, fax 617-332-4522

Travel Registration and History Form

Name _____ Age _____ Occupation _____

Home Address _____

Work Address _____

Home Phone _____ Work Phone _____ Fax No _____

Emergency Contact Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance _____ Insurance No _____

Date of Birth _____ Social Security No _____ Place of Birth _____

Primary Care Physician Name _____ Phone _____

Address _____

Medical History Do you have any current illnesses affecting the:

Organ/System	Details
<input type="checkbox"/> Heart	
<input type="checkbox"/> Lung	
<input type="checkbox"/> Kidney	
<input type="checkbox"/> Gastrointestinal Tract	
<input type="checkbox"/> Liver	
<input type="checkbox"/> Musculoskeletal System	
<input type="checkbox"/> Endocrine Glands	
<input type="checkbox"/> Nervous System	

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever been admitted to hospital? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Are you pregnant now or planning to become pregnant? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Are you HIV positive or have any other immune system deficiency? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Do you have a blood disorder? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Do you have any illness related to the thymus gland? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Have you ever had hepatitis? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Have you ever been treated for cancer or lymphoma? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Do you have psoriasis or any other chronic skin conditions? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Have you ever had seizures? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Do you have an irregular heart beat? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Have you ever had an operation on your spleen? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Have you lived, visited or worked in countries in the developing world? | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Have you ever been treated for a tropical disease such as malaria? yes no
 Have you taken steroids in the past three months? yes no
 Please list prescription and non prescription medications which you are taking now.

Are you allergic to any medications or vaccinations? yes no
 Are you allergic to eggs? yes no
 Do you have any other allergies? yes no
 Do you have asthma? yes no
 Have you had chickenpox, measles, mumps, or rubella? yes no

Provide details for anything answered 'yes' above.

Immunizations Please provide a detailed immunization history with dates for the following vaccines:

Vaccines	Details
<input type="checkbox"/> Tetanus/Diphtheria	
<input type="checkbox"/> Measles/Mumps/Rubella	
<input type="checkbox"/> Varicella (chickenpox)	
<input type="checkbox"/> Polio	
<input type="checkbox"/> Meningococcal Meningitis	
<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pneumococcal	
<input type="checkbox"/> Typhoid	
<input type="checkbox"/> Yellow Fever	
<input type="checkbox"/> Rabies	
<input type="checkbox"/> Japanese Encephalitis	

Travel Plans Reason for travel: work family visit vacation adventure travel
 Departure Date _____ Return Date _____ Cruise yes no

List in order the countries that you will be visiting, the anticipated length of stay at each destination, and check all vacation descriptions that apply for each destination.

Country	Length of Stay	<input checked="" type="checkbox"/> Urban	<input checked="" type="checkbox"/> Rural	<input checked="" type="checkbox"/> Camping	<input checked="" type="checkbox"/> Backpacking	<input checked="" type="checkbox"/> High Altitude