

**OMAHA TRAVEL CLINIC, PC
PATIENT INFORMATION FORM**

FAX THIS FORM TO KIM AT 402.934.6518
(For questions, call Kim at 402.934.6506)

Last Name		First Name		MI	SSN
Home Phone		Work Phone	Mobile Phone		DOB
Address					
PRIMARY/REFERRING PHYSICIAN					
NATURE OF TRIP					
Business___ Pleasure___ Mission___ Urban___ Rural___					
DESTINATION		DEPARTURE DATE		LENGTH OF STAY	
MEDICAL HISTORY					
ACTIVE HEATH PROBLEMS?		Yes ___ No...___		PRIOR TRAVEL HEALTH PROBLEMS?	
				Yes ___ No ___	
ALLERGIES?		IF YES, LIST:			TO EGGS OR LATEX
Yes ___ No ___					Yes ___ No ___
CURRENT MEDICATIONS:					
PREGNANT OR PLANS FOR PREGNANCY WITHIN 3 MONTHS?				Yes ___ No ___	
WILL SOMEONE BE TRAVELING WITH YOU?			Yes ___ No ___		RELATIONSHIP?
VACCINES: HAVE YOU EVER HAD ANY OF THE FOLLOWING?					
Immunization	Last Given	Immunization	Last Given	Immunization	Last Given
___ Hepatitis A Immunoglobulin		___ Polio oral ___ IPV		___ Tetanus/Diphtheria	
___ Hepatitis A Vaccine Adult ___ Pediatric		___ Japanese Encephalitis		___ Tetanus/Diphtheria /Pertussis	
___ Hepatitis B		___ Meningococcal conjugate (MCV4)		___ Typhoid Oral ___ IM	
___ Influenza (flu)		___ Meningococcal polysaccharide (MPSV4)		___ Yellow Fever	