Pre-Travel Intake Form

Welcome to Good Day!

PATIENT INFORMATION

Patient's Name:____ Birthdate:___________ Age:_________

Address:____City:________________State:____Zip:________

Phone (home):____________________Phone (cell):______________________Email:_____________________

How can we let you know when your prescription is ready (circle one)? Text / Phone Call

Emergency Contact:______________________ Relationship:________ Phone Number:___________________

Employer:____Occupation:_____________________________

PRIMARY CARE PHYSICAN INFORMATION

Name:____ Phone______________________________

Address:____

We will send a copy of your immunizations to your doctor.

TRAVEL INFORMATION

Destination (City, Country) ***list in chronological order***	**Length of Stay**	**City or Rural**

TRAVEL INFORMATION

Please mark all that will apply during your travels:

☐ Tourist	☐ Missionary	☐ Large Resort	☐ Safari	☐ High Elevation
☐ Student	☐ Teacher	☐ Small Hotels	☐ Diving	☐ Other (list)
☐ Business	☐ Field Work	☐ Hostels	☐ Camping	☐ __________
☐ Adoption	☐ Cruise Ship	☐ Staying with family	☐ Climbing	☐ __________
Traveling with:	☐ Your Company	☐ Group	☐ School/Church	How many:

MEDICAL HISTORY

Please list all medications:	
1.	3.
2.	4.
Please list all allergies (medication, antibiotics, vaccine):	
1.	2.

Do you have seizures/epilepsy?	☐ Y	☐ N	Do you have stomach/bowel conditions?	☐ Y	☐ N
Do you have diabetes? If, yes do you use insulin or other refrigerated medication?	☐ Y	☐ N	In past 3 months have you had a blood or plasma transfusion or been given immune globulin?	☐ Y	☐ N
Do you have high blood pressure or take blood pressure medication?	☐ Y	☐ N	Do you have tuberculous or have tested positive for it?	☐ Y	☐ N
Do you have heart problems? (cardiac arrhythmias, irregular heart beat)	☐ Y	☐ N	Do you have depression, anxiety or psychiatric disorders?	☐ Y	☐ N
Do you have immune disorder/deficiency?	☐ Y	☐ N	Do have a nerve disorder or have a history of Guillian-Barre Syndrome?	☐ Y	☐ N
Do you have psoriasis or any skin disorders?	☐ Y	☐ N	Are you allergic to bee stings?	☐ Y	☐ N
Do you or any person you live with have cancer, leukemia, AIDS, take prednisone, chemotherapy, or radiation?	☐ Y	☐ N	Are you allergic to eggs, yeast, or any other foods? Are you allergic to thimerosal, chrysanthemums? (circle)	☐ Y	☐ N
Do experience nightmares or insomnia?	☐ Y	☐ N	Do you get motion sickness?	☐ Y	☐ N
Do you have kidney impairment?	☐ Y	☐ N	Do you get altitude sickness?	☐ Y	☐ N

Prior Immunizations and Dates:

Flu:___________	Hep A: ________
Pneumonia: __________	#Doses:_____
Polio:_________	Hep B: ________
Meningitis: ___________	#Doses:_____
Varicella: ____________	Twinrix: _______
MMR: _______________	#Doses:_____
Tetanus/Diptheria: ______________	Rabies: _______
	#Doses:_____
Typhoid:_____________	Japanese Encephalitis: ____________
Oral/Injection:_______	
Antimalarial Medication: ____________________	#Doses:_____

Women:

Are you on birth control?	☐ Y	☐ N
Are you pregnant?	☐ Y	☐ N
Are you planning on becoming pregnant 3-10 months prior, during or after the trip?	☐ Y	☐ N
Are you breastfeeding?	☐ Y	☐ N

Please list any other medical conditions or concerns you may have (*fear of needles, anxiety attack, heart attack)*:

____

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I acknowledge that I am the traveler and an adult or parent or legal guardian of the above minor traveler and have requested a pre-travel consultation from Good Day Pharmacy for general information relevant to my above travel plans I have identified. I understand and agree:

- **The above information is accurate to the best of my knowledge.**
- **I acknowledge the pre-travel consultation may not provide an exhaustive list of all risks associated with or conditions to the above travel plans; it is not being conducted for diagnostic or treatment purposes and does not constitute medical advice.**
- **I agree to full financial responsibility of the pre-travel consultation, understand insurance will not cover the pre-travel consultation, and I am responsible for the fees associated with the visit. The pre-travel consultation does not include any immunizations or medications. I understand not all travel medications are on the pharmacy protocol and the pharmacy will attempt to obtain all necessary prescriptions from my primary care doctor. I will be responsible for obtaining any recommended prescriptions the pharmacy is unable to obtain. I understand my insurance may not cover all prescriptions and I am responsible for payment of medication and immunizations.**

____ ___/___/_____

(Name, printed/ under 18 year of age Parent/Guardian) (Date)

____

(Name, signed)