



IHA Midwest Travel Care - Itinerary Worksheet

Traveler Name: _____ Birthdate: _____ Appt. Date: _____

Is this your first visit to IHA Midwest Travel Care? Yes No If no, approximate last visit date: _____

History of international travel; list of countries visited: _____

Current Travel Plans – Include both ground and air stops (if needed use additional pages for more stops)
Departure Date _____ Length of trip _____ days

Country	Nearest City	days at location	Visited Before?	Are you likely to travel to this destination in the next year?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Will you be in Rural Urban areas?

What will be your accommodations (Hotels, houses, cruise ship, hostel etc.)? _____

Are you likely to visit: Schools Hospitals Orphanages?

What is the purpose of this trip? Visit Family Business Vacation Mission/Service

Education Adoption Other _____

Have you ever taken **malaria** medication while travelling? Yes No

If yes, which malaria medication(s): _____

How did you tolerate it?: _____

Please list information that would make this visit more helpful to you:
