Southwest Utah Public Health Department

INTERNATIONAL TRAVEL CLINIC - LDS MISSIONARIES

TODAY'S DATE _____
NAME: _____ DOB: _____ AGE: _____ Phone # _____

TRAVEL INFORMATION

Date entering MTC _____ MTC Location _____ Length of Mission _____
Country of Mission _____ Name of Mission _____

PERSONAL MEDICAL INFORMATION

☐ YES ☐ NO - Have you previously traveled to any developing country?
☐ YES ☐ NO – Did you receive your childhood vaccines?
☐ YES ☐ NO – Have you ever had chicken pox disease or the vaccine series?
☐ YES ☐ NO - Are you currently under a physicians care for any health problem?
☐ YES ☐ NO – Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?
☐ YES ☐ NO – Have you taken cortisone, predisnone, other steroids, anti-cancer drugs, or had radiation treatment in the last 3 months?
☐ YES ☐ NO – Do you have any seizure or brain problems?
☐ YES ☐ NO – Have you received gamma-globulin or blood transfusions within the past year?
☐ YES ☐ NO – Have you received any vaccinations or a TB test in the past 4 weeks?
☐ YES ☐ NO – Have you ever taken anti-malarial medication? If yes, what medication: _____
Did you tolerate it well? ☐ Yes ☐ No
☐ YES ☐ NO - Are you at risk for blood born infections such as: HIV, AIDS, or Hepatitis B and C?
(Risks include: blood transfusions, unprotected sexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.)
☐ YES ☐ NO - *(Females)* Is there any chance you could be pregnant?

ALLERGIES

☐ YES ☐ NO – Have you ever had a serious or life threatening allergic reaction?
Are you allergic to any of the following?
☐ Sulfa ☐ Neomycin ☐ Streptomycin ☐ Polymyxin B ☐ Eggs ☐ Baker's Yeast ☐ Gelatin ☐ Bee Stings
OTHER ALLERGIES please list: _____

PAST MEDICAL HISTORY (check all that apply) ☐ **NONE**

☐ Hepatitis/ liver disorders ☐ Myesthenia gravis ☐ Prostate problems ☐ Diabetes
☐ Thrombophlebitis/ blood clots ☐ Seizures/ epilepsy ☐ Kidney disease ☐ Heart disease/ attacks
☐ Recurrent pneumonia ☐ Mental / emotional illness ☐ Irregular heart rhythms ☐ HIV or AIDS
☐ Splenectomy ☐ Thymus disease/ thymectomy ☐ Blood thinning meds ☐ Psoriasis
☐ Stomach or bowel conditions ☐ Retinal or visual field changes ☐ Recent surgeries
☐ Problems treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis)
☐ List any other medical problems: _____

MEDICATION INFORMATION

(List any medications you are taking, include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking

Medication	Reason for Taking

Southwest Utah Public Health Department- Travel Intake Form
All information is strictly confidential ***(PLEASE PRINT)***

CLIENT INFORMATION:

Name:_____ **Mother's Maiden Name:**_____
Last *First* *MI*

Address: _____
Street / P. O. Box *City* *State* *Zip Code*

Telephone: (_____) _____-_____ Circle One: Home Cell Message Work

Telephone: (_____) _____-_____ Circle One: Home Cell Message Work

Birth Date: _____/_____/_____ **Age: _____** **Gender: □ Male □ Female**
M D YR

Race: □ White □ Black □ Asian □ Other □ Indian/Am. Native □ Native Hawaiian/Pacific Islander

Hispanic/Latno: □ Yes □ No

Medicaid: □ Yes □ No ID Number: _____

Medicare: □ Yes □ No ID Number: _____

Private Insurance: □ Yes □ No Insurance Company: _____
Subscriber's Name:_____ Subscriber's Date of Birth_____

If no insurance and you wish to have assistance with the cost of vaccines:
Gross Monthly Income: $_____ Number of Household/Family Member: _____

If child, name of parent:_____

CONSENT/PRIVACY

I, the patient (or the undersigned if other than the patient), understand that I am responsible for all expenses incurred at the Southwest Utah Public Health Department (SWUPHD) International Travel clinic on my behalf (or on behalf of the patient). SWUPHD may be able to bill my health insurance, Medicare/Medicaid, but I understand that I am responsible for all co-payments, deductibles, immunizations, counseling fees, and other services not covered by my insurance, Medicaid/Medicare plan. I agree to pay all fees at time of service.

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated be given to the person named above for whom I am authorized to make this request. I agree that immunization information (only) may be included in a centralized, state-wide database and shared with other health care providers as necessary. I HEREBY RELEASE THE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND THEIR EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS, TRAVEL ADVICE AND PRESCRIBED MEDICATION.

I have been provided with a copy of SWUPHD's Notice of Privacy Practices.

Signature _____ Date _____

For Office Use Only

TRAVEL VISIT CHARGES

_____ Missionary $25

$_____ Total Consultation Fees
$_____ Total Immunization Charges
$_____ Other _____ Paid By:
$_____ Amount Received Card / Cash / Check / Medicaid / Billed _____