*Patient Label Here*

**Patient Name:** _____

**Date of Birth:** / /

**Contact Ph. #(s):** _____

**Departure Date:** / /

**Return Date:** / /

PACIFIC PALISADES Medical Group

CLINICAL AFFILIATE OF THE UCLA MEDICAL GROUP

# Travel Clinic Intake Form

| I. Itinerary: List in Order | Rural | Urban | Length of Stay-Backpack/Trekking |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

## II. Medical History

| Chronic Medical Problems | Allergies | Current Medications |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | **Prior Surgery** | |
| 4 | | |
| 5 | | |
| **Primary Physician** | **Smoking Status** | **Occupation** |
| | / /never | |
| | / /previous smoker; quit_____ | **Gynecology (Women Only)** |
| **Other Treating Physicians** | / /active_____ppd | Contraception: |
| | **Alcohol Use** | Pregnant or planning to be? |
| | / /none--/ /mild--/ /mod--/ /heavy | Last menstrual period |

## III. IMMUNIZATIONS

| *MM/DD/YY* | Previous | Previous | Ordered | Ordered | Ordered | Ordered | Ordered | Ordered |
|---|---|---|---|---|---|---|---|---|
| **Cholera** | | | | | | | | |
| **Hepatitis A** | | | | | | | | |
| **Hepatitis A-booster** | | | | | | | | |
| **Hepatitis B-series** | | | | | | | | |
| **Hepatitis B-booster** | | | | | | | | |
| **Hepatitis A,B combo** | | | | | | | | |
| **Influenza** | | | | | | | | |
| **Japanese Enceph** | | | | | | | | |
| **Meningococcal** | | | | | | | | |
| **MMR** | | | | | | | | |
| **Pneumovax** | | | | | | | | |
| **Polio-injectable** | | | | | | | | |
| **Rabies prophylaxis** | | | | | | | | |
| **Tdap (Adult DTaP)** | | | | | | | | |
| **Tetanus/Diptheria** | | | | | | | | |
| **Typhoid-injectable** | | | | | | | | |
| **Typhoid-oral** | | | | | | | | |
| **Yellow Fever** | | | | | | | | |
| | | | | | | | | |

## IV. Please Mark Service Level Requested:

☐ Physician Visit (vaccines, prescriptions, advice) [TVMD]

Nurse Visit (vaccines only) [TVNU]

**Nurse Vital Signs:**

Height_____'_____" Wt:_____lbs. BP_____/_____ Pulse_____