Center for Pharmacy Care TRAVEL Consult

INITIAL INTAKE FORM

Intake Date: _____ / ______/ _______
MM DD YEAR

BASIC INFORMATION:

Name (first and last):___________________________________

Age:________ Phone Number:___________________________

Date of Birth:____/_____/_________ Email:________________

Gender: ☐ Male ☐ Female
☐ Pregnant
☐ Breastfeeding

Ethnicity:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black (not of Hispanic origin)
  - ☐ Hawaiian or Pacific Islander
  - ☐ Hispanic
- ☐ Indian Sub-Continent
- ☐ White (not of Hispanic origin)

Allergies:

- ☐ No Known Allergies
- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine
- ☐ Egg
- ☐ Latex
- ☐ Neomycin
- ☐ Gelatin
- ☐ Other ________________________

Occupation:_______________________________

Do you smoke?

- ☐ Yes
- ☐ No

Have you had your spleen removed?

- ☐ Yes
- ☐ No

Physician:__________________________________

Address:___________________________________

____

Phone Number: ____________________________

Current Disease States:

- ☐ Diabetes (Type I or Type II)
- ☐ Chronic Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Heart Failure
- ☐ Heart Arrhythmia
- ☐ Rheumatoid Arthritis
- ☐ Psoriasis
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Epilepsy
- ☐ Cancer
- ☐ G6PD Deficiency
- ☐ Other

____

Vaccination History:	Please attach a current copy of vaccination history to this document and return to the Center for Pharmacy Care:
☐ All childhood vaccines received Please check any vaccine listed below that was received as an adult: ☐ Varicella (Chickenpox) ☐ Hepatitis A ☐ Hepatitis B ☐ Human papillomavirus (HPV) ☐ Influenza ☐ MMR (Measles, Mumps, Rubella) ☐ Meningitis ☐ Pneumonia ☐ Shingles ☐ Tdap (Tetanus, diphtheria, pertussis)	Center for Pharmacy Care 600 Forbes Ave 215D Student Union Pittsburgh PA 15282 412-396-2155 fax:412-396-2161

Current Medication List:

Name and Strength	Directions	What are you taking this for?

Past Medication List (stopped within past 3 months):

Name and Strength	Directions	Discontinuation Date

1) Where are you traveling? Rural or urban area?

____

2) How long will you be gone?

____

3) When do you leave?

____

4) Where will you be staying?

____

5) Reason for travel?
- ☐ Vacation
- ☐ Business
- ☐ Visiting home country
- ☐ Planning adoption
- ☐ Medical procedure
- ☐ Other_________________

6) How did you find out about this clinic?
- ☐ Advertisement on Duquesne campus
- ☐ Physician/Healthcare Provider
- ☐ Travel agent
- ☐ Internet
- ☐ Other________________________

7) Would you have sought out travel vaccines and education if you have had not heard about this clinic?
- ☐ Yes
- ☐ No

If yes to question 7, where would you have gone/who would you have consulted?
- ☐ Health Department
- ☐ Physician
- ☐ Other travel clinic
- ☐ Internet
- ☐ Travel agent
- ☐ Family/Friends
- ☐ Other____________________________

If no to question 7, please indicate the reason why.
- ☐ Was not aware needed to do so
- ☐ Not concerned about getting sick
- ☐ Was told it was not necessary
- ☐ Have previously traveled to destination
- ☐ Have been vaccinated/educated in past
- ☐ Other_____________________________

Notes