CREELMAN FAMILY PRACTICE PLLC
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PREPARING TO TRAVEL

International Travel

We would be happy to assist you with pre-travel information, vaccinations or prescriptions. Staying healthy and preventing illness and disease exposure when traveling internationally requires preparation and learning about the part of the world you are going to visit.

Preparing to Travel visit 6-8 weeks in advance

In order for us to best assist you, we would like you to schedule a Preparing to Travel visit at least 6-8 weeks prior to your departure. This should allow sufficient time for you to receive required vaccinations and gather the supplies you may need for your trip.

Preparing for your visit

You may access our website www.creelmanfamilypractice.com to download, print, and complete the **"Preparing to Travel"** packet. You may also call our office to have a packet sent to you or drop by to pick one up in advance. The forms will provide a place for you to share your itinerary, the countries you will be traveling to, including the airport connections, the locations where you will be spending the night, and the outdoor activities planned as well as your vaccination history.

Please return the completed packet at least 1 week prior to your appt.

Schedule your appt.

Call (360) 757-0027 to schedule your Pre-travel visit. Our office is open Monday - Saturday. Your Travel Clinic appointment is $59 due at scheduling, which does not include the cost of vaccinations, if any. We accept all major credit cards or cash for these services.

Call (360) 757-0027
to schedule your Preparing to Travel appt.

PREPARING TO TRAVEL: ITINERARY

Name	**Birthdate**
Address	**Gender Weight**
	Phone
Healthcare Provider Name	
Address	

List in order of travel the countries you will be visiting. Include any airport connections and the dates visiting.

Countries	Dates in country Number of days	Regions, rural or urban, cities and if > 6,000 feet in elevation
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

PREPARING TO TRAVEL: ACTIVITIES

Where will you be spending the night? (hotel, cabin, tent, house)
What will you be doing on your trip?
Please list any outdoor activities such as hiking, backpacking, scuba diving, swimming
Have you traveled internationally in the past? List countries
Other information you would like to share?

At your appointment we will need your vaccination records, a list of allergies, a list of past and present medical issues, surgeries and a list of current medications with dosages.

TRAVEL PATIENT PERSONAL INFORMATION

Today's Date_____

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Name _____ Age _____ Birthdate ____/ ____/ ____

Marital Status □ single □ married □ divorced □ separated □ widowed

Occupation (if retired list previous occupation) _____

Recent Doctor(s) _____Last Exam Date _____

Wish to share your medical record with a family member? □ yes □ no Name _____ Relationship _____

Previous Surgery (month/year) □ check if none

_____ _____ _____

_____ _____ _____

Other Surgeries, Hospitalizations or Major Illnesses *List any ongoing medical contitions*

_____

_____

Current Medication and Supplements (prescribed and over the counter) *Please list dosage*

name_____ name_____

name_____ name_____

name_____ name_____

name_____ name_____

name_____ name_____

Allergies (meds, foods, seasonal) _____

_____

Weight Average last 5 years _____

Smoking History of smoking? □ yes Packs a day_____ Year first started_____ Date quit _____

Alcohol Do you drink alcohol? □ yes □ no Average # of drinks _____ □ day □ week □ month □ year

Ever felt you should cut down on your drinking? □ yes □ no

Morning drink to steady nerves or rid of a hangover?□ yes □ no

Felt annoyed by others criticizing your drinking? □ yes □ no

Felt bad or guilty about your drinking? □ yes □ no

Drugs Street drugs ever used? □ yes □ no □ currently using

name_____ frequency_____

name_____ frequency_____

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PLEASE CONTINUE FORM ON BACK

TRAVEL CLINIC

Family Health History

	Age if living	Age at death	Major illnesses
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
# ___	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
# ___	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please indicate illnesses of relatives including aunts, uncles, cousins, grandparents:

alcoholism_____
asthma, allergies_____
bleeding disorder_____
cancer, leukemia_____
diabetes _____
emphysema_____
glaucoma_____
hearing loss_____
heart trouble_____
high blood pressure_____
kidney disease_____
liver disease_____
migraines_____
sickle cell anemia_____
stroke_____
thyroid disease_____
tuberculosis_____
other _____

Past Month Health History *Circle any of the symptoms which have troubled you in the past **month**.*

Pain in your stomach, back, arms, legs, joints, headache
Chest pain
Menstrual pain, menstrual problems
Sexual pain, sexual problems
Dizziness
Fainting spells
Heart pounding, heart racing
Unusual shortness of breath
Tired, low energy
Constipation, loose bowels, diarrhea
Nausea, indigestion, insomnia
Eating out of control
Little interest or pleasure in doing things
Depressed, feeling down, hopeless, tearful
Nerves, anxious, on edge, explosive
Worrying about many things
Anxiety attacks, sudden panicky feeling

Past Year Health History *Circle any of the symptoms which have troubled you in the past **year.***

Unexplained fever, chills, sweats, bleeding, rashes
Weight change, weight concern
Eating issues causing vomiting or diarrhea
Memory loss, poor balance, difficult speech
Weakness in arms or legs left or right
Blurred vision not eyeglass corrected
Double vision, light flashes, visual loss, halos, eye pain
Swollen glands, unexplained lumps steadily enlarging
Swollen joints, painful joints
Changing moles
Hearing or ear problems
Increased thirst
Too cold or warm most of the time
Breast lump, pain or nipple discharge
Difficulty swallowing
Frequent heart flutters or unusual heart beats
Snoring, pauses in breathing when asleep
Decreasing exercise ability
Ankle swelling, leg cramps with walking
Wheezing
Cough lasting over one month
Night sweats
Change in bowel habits
Rectal bleeding, black stools
Urinating more than one time per night
Bloody urine
Urine leakage
Pain with urination or frequency

Women

Date of last period _____
Birth control method _____
Are you pregnant or trying to become pregnant?
□ yes □ no

Men

Sores or discharge from penis
Lump in testicle
Slow or difficult urination