



Travel With Care

The Travel Medicine Program
St. Luke's- Roosevelt Hospital Center

Name:

D.O.B.

Today's Date:

Do you have a history of allergic reactions to any of the following? If yes, please describe.

Substances	Yes	No	Your Reaction
Chickens			
Eggs			
Insect Bites			
Bee Stings			
Sulfa Drugs			
Neomycin, polymixin B or streptomycin			
Mercury or mercury derivatives (thimerosal)			
Yeast			

Will you be traveling with an infant or child?

Y N

If yes, please list ages _____

Are you in good health?

Y N

If no, explain _____

Do you have any chronic diseases or major illnesses such as diabetes, leukemia, lupus, Hodgkin's disease, tuberculosis, cancer, AIDS?

Y N

If yes, explain _____

Are you HIV positive?

Y N

Do you have dermatitis, eczema, rash or other skin conditions?

Y N

If yes, describe condition _____

Have you had a fever in the past 48 hours?

Y N

Have you ever had a convulsion, seizure or epilepsy?

Y N

Please list any medications (prescription or over-the-counter) you are currently taking: