APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
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Pre-Travel Intake Form

Please complete and return via email or fax at least 24 hrs prior to your appointment

Name: _____
Last First Middle Initial

Address: _____ Phone: _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____/_____/_____

Pharmacy:

Name _____ **Phone** _____

Referral source: ☐ Physician ☐ Self ☐ Other _____

Reason for travel: ☐Vacation ☐Business ☐Volunteer ☐Education ☐Adoption ☐Visiting Friends and/ or Family

Itinerary: Departure date _____ Length of Stay _____

Please list in chronological order the **Cities and Countries** you are scheduled to visit, including layovers:

Destination	Length of Stay

Please answer the following questions

Are you…

Staying in air conditioned accommodations?	Yes ☐	No ☐
Visiting rural areas?	Yes ☐	No ☐
Visiting only urban areas?	Yes ☐	No ☐
Visiting both urban and rural areas ?	Yes ☐	No ☐
Staying and / or eating with locals/ friends / family	Yes ☐	No ☐
Visiting usual tourist areas?	Yes ☐	No ☐
Straying from the usual tourist areas?	Yes ☐	No ☐
Traveling to areas greater than 24 hrs from health care?	Yes ☐	No ☐

Medical History

1. Do you have any known allergies? Yes ☐ No ☐

If yes, please list _____

2. Have you ever had a reaction to a bee sting? Yes ☐ No ☐

3. Do you have allergic reactions to eating eggs? Yes ☐ No ☐

4. Do you have allergic reactions to antibiotics? Yes ☐ No ☐

If yes, please list _____

_____

5. Are you currently pregnant? Yes ☐ No ☐

6. Are you being treated for any medical conditions? Yes ☐ No ☐

If yes, please list _____

7. Do you have a history of any of the following?	YES	NO
Seizures / epilepsy		
Nightmares		
Depression		
Anxiety disorders		
Psychiatric disorders		
Immune deficiency/Disorder		
Psoriasis		
G6PD Deficiency		
Irregular heart beat / cardiac arrhythmias		
Thymus Gland surgery or disorder (e.g. myasthenia gravis)		
History of altitude sickness		

8. Are you currently taking any medications? Yes ☐ No ☐

If yes, please list: _____

_____

_____

9. Name of Primary Care Provider _____ Phone _____

10. Routine Immunizations: Provided by your Primary Care Provider? Yes ☐ No ☐

Up to date? Yes ☐ No ☐ Unsure ☐

11. Have you received any immunizations in the last 4 weeks? Yes ☐ No ☐

If yes, which ones

Vaccine **Date**

_____

_____

_____

12. Have you ever received any vaccines for travel? Yes ☐ No ☐

If yes, which ones and when did you receive them (please list)

Vaccine **Date**

_____

_____

_____

_____

_____

_____

13. Have you received immune globulin, a blood transfusion or any blood products in the last year?

Yes ☐ No ☐

_____

Signature Date