CONCORD HOSPITAL
Medical Group
Infectious Disease
~ International Travel Clinic

Infectious Disease is a member of Concord Hospital Medical Group, a department of Concord Hospital

Memorial Medical Office Building
246 Pleasant Street, Suite 104
Concord, New Hampshire 03301
(603)230-1939 fax (603)227-7568
concordhospital.org

Travel Clinic Itinerary and Health History Form

Must be completed and returned at least five days before your travel consult

Name of Traveler: ______________________________ Date of Birth: _______________
Address: ____
Phone: ______________________________ Email _________________________
Primary Care Provider: ____________________
Insurance provider: ___________________________ Policy # _______________

1.) Please list in order the countries you intend to visit or pass through and the name of the city, town, or village you will be staying in. Also, list how many days you plan to stay in each area, and type of accommodations i.e. hotel, tent, family home etc. Alternatively, please mail or fax a copy of your detailed itinerary with this form to our office.

Country	Name of Town/Village/ City	City or Rural	Departure Date	Length of Stay	Type of accommodations

Health History

2.) Do you have any allergies to any medications/food/vaccines? If yes, please list and describe:

3.) Are you pregnant? Due Date: Last Normal Period:
4.) Do you have a history of Guillain-Barré Syndrome?
5.) Do you have an Immune Disorder?
If yes please specify:

6.) Are you receiving any steroids or medication that affects your immune system?
If yes please list:

7.) Do you have any chronic diseases or are you under a doctor's care for any medical problems?

If yes, please explain:

8.) Have you been immunized against any of the following diseases? Yes or No
If yes, please write the date received and a description of your reaction, if any.

Vaccine	Yes	No	Date	Reaction (if any)
Hepatitis A				
Hepatitis B				
Typhoid				
Yellow Fever				
Meningitis				
Influenza				
Polio				
Tetanus Diptheria (TD) or TDaP				
MMR (Measles/Mumps/Rubella)				
Covid-19				

9.) Please list all medications (prescription or over the counter) you are currently taking:

Name of Medication Dose Directions

10.) What pharmacy and location do you use for prescriptions?

TRAVEL CLINIC WAIVER

I understand that I am responsible for payment for the educational/counseling session provided by the Concord Hospital International Travel Clinic at booking (fee determination based on itinerary and number of people traveling). I have also been advised that if I do not arrive for your travel consult at your scheduled time, or if you cancel with under five business days, $50 per traveler will be retained for consultation preparation and the remainder will be refunded via check from Concord Hospital. I, also, understand that Concord Hospital will bill my insurance for all vaccines administered. However, if the vaccines are not covered by my insurance, for any reason, I agree to pay any remaining balance as outlined by the Concord Hospital International Travel Clinic (specific immunization pricing available upon request)

If I am uninsured/self-pay, I will pay for the vaccines on the day of service, in full.

Signature: ____ Date: ___________

(If patient is under age 18 signature of Parent/Guardian)

Printed Name: ____

Please mail to 246 Pleasant st. Suite 104, Concord, NH 03301,
fax to (603)227-7568 or return via myPatient Connect
at least *1 WEEK prior to your appointment* or your appointment may be cancelled.