

WORKMED TRAVEL CLINIC INTAKE

Appointment Date: _____ **Appointment Time:** _____

Patient Info:

Name: _____ Telephone: (H) _____
DOB: _____ (W) _____
PCP: _____

Travel Plans:

Destination(s): _____
Departing Date: _____ Length of Stay: _____
Purpose of Trip: _____
Activities Planned: _____

Medical History:

Recent Illnesses: _____
Chronic Illnesses: _____
Allergies: _____
Medications: _____
Vaccination/Disease History: _____

Recommended/Required Vaccines & Medications by CDC & Nurse

Nurse's Signature: _____

Vaccines/Medications Ordered (See attached consent forms)

Vaccinations

Prescriptions

Physician's Signature: _____

Jonathan Torres, MD