CORONA DOCTORS MEDICAL CLINIC
802 MAGNOLIA AVE SUITE 106
CORONA CA 92879
(951)371-9500

TRAVEL MEDICINE QUESTIONNAIRE

Patient Name:
DOB:
CDMC No:

PLEASE PRINT

LEGAL NAME OF TRAVELER:
GENDER: DOB:
HOME ADDRESS:
CITY: STATE: ZIP:
HOME PHONE: CELLULAR-PHONE:
PRIMARY CARE PHYSICIAN: PHONE:
EMERGENCY NOTIFICATION: PHONE:
RELATIONSHIP: PHONE:

ITINERARY		
DEPARTURE DATE:	RETURN DATE:	LENGTH OF TRIP

PURPOSE OF TRAVEL: PLEASE CHECK ALL THAT APPLY			
BUSINESS	VACATION	FIELD WORKED	RELOCATION

TYPE OF TRAVEL: PLEASE CHECK ALL THAT APPLY			
GROUP/TOUR	INDEPENDENT	VACATION	CRUISE/OTHER

ACCOMODATIONS: PLEASE CHECK ALL THAT APPLY			
COMPOUND	HOTEL/RESORT	PRIVATE HOME	CRUISE SHIP

DESTINATION, INCLUDING STOPPVERS. LIST IN ORDER

COUNTRY	CITY	DURATION	URBAN (X)	RURAL (X)

THIS IS NOTICE TO IMFORM YOU THAT MOST HEALTH CARE PLANS DO NOT OFFER COVERAGE FOR IMMUNIZATIONS FOR THE PURPOSE OF TRAVEL. THEREFORE, CORONA DOCTORS MEDICAL CLINIC WILL NOT FILE A CLAIM FOR THIS VISIT WITH YOUR HEALTH CARE PLAN. PAYMENT, IN FULL, IS EXPECTED AT THE TIME OF SERVICE. FURTHER, THESE SERVICES ARE NOT SUBJECT TO ANY EXISITING DISCOUNT POLICIES. YOU MAY CHOOSE TO FILE A CLAIM DIRECTLY WITH YOUR HEALTH PLAN. YOU MAY CHOOSE TO CONTACT YOUR HEALTH PLAN PRIOR TO THE VISIT TO REQUEST A BENEFITS REVIEW FOR "TRAVEL MEDICINE SERVICES." IF YOU ARE ABLE TO BRING WRITTEN PROOF FROM YOUR HEALTH CARE PLAN SHOWING EVIDENCE OF COVERAGE FOR "TRAVEL MEDICINE" SERVICE, CORONA DOCTORS MEDICAL CLINIC WILL FILE THE CLAIM ON YOUR BEHALF.

REVIEWED AND ACCEPTED: ______________________________ DATE: ____________________:

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	HAD DISEASE	VACCINE#1 DATE	VACCINE#2 DATE	VACCINE #3 DATE	NOT KNOWN
CHIECKEN POX					
HEPATITIS A					
HEPATITIS B					
RABIES					
JAPANESE ENCEPHALITIS					
MEASLES					
MUMPS					
RUBELLA					
MENINGITIS					
POLIO					
PNEUMOCOCCAL					
INFLUENZA					
TETNUS/DIPTHERIA					
TYPHOID INJECT.					
TYPHOID ORAL					
YELLOW FEVER					

DO YOU HAVE AN "INTERNATIONAL CERTIFICATE OF VACCINATION?	YES OR NO
HAVE YOU EVER FAINTED OR HAD A REVERSE REACTION TO ANY OF THE FOLLOWING?	BEE STINGS: YES OR NO VACCINES: YES OR NO

DO YOU HAVE CANCER, LEUKEMIA, AIDS, OR OTHER IMMUNE SYSTEM PROBLEMS? YES OR NO
DO YOU TAKE CORTISONE, PREDNISONE, OTHER STEROIDS, ANTI CANCER DRUGS OR HAVE/HAD RADIATION THERAPY? YES OR NO
HAVE YOU RECEIVED A BLOOD TRANSFUSION, BLOOD PRODUCTS OR IMMUNE GLOBIN IN THE PAST YEAR? YES OR NO
HAVE YOU HAD ANY IMMUNIZATIONS IN THE PAST 4 WEEKS? YES OR NO
IF YES, PLEASE EXPLAIN:
HEALTH HISTORY

WEIGHT:	HEIGHT:	ALLERGIES

MEDICATIONS (LISTS ALL MEDICATIONS, INCLUDING DOSAGES)

PRESCRIPTION	NON-PRESCRIPTION

MEDICAL CONDITIONS:
PREVIOUS SURGERY:
DO YOU HAVE A HISTORY OF THE FOLLOWING?

NIGHTMARES: YES OR NO	PSORIASIS: YES OR NO	SEIZURE/EPILEPSY: YES OR NO

PSYCHIATRIC DISORDER: YES OR NO	STOMACH/COLON PROBLEMS: YES OR NO

WOMEN: TYPE OF CONTRACEPTIVE-	PREGNANT: YES OR NO	PLANNING PREGNANCY: YES OR NO	NURSING: YES OR NO

I VERIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:____