ADVANCED PEDIATRIC ASSOCIATES

PRE-TRAVEL CONSULT: PEDIATRIC HISTORY FORM

Patient Name: **Date of Birth**:

Arrival Date	Country	City / Region	Length of Stay
If more than 3 destinations, please explain in note area below.			

Type of Travel:	□ Visiting family or friends □ Tourism □ Other _____
Accommodations:	□ Hotel □ Family home □ Other _____
Setting:	□ Urban □ Rural □ Combination
Anticipated activities:	□ Large group gathering (including Hajj) □ Recreation (especially diving, spelunking and climbing) □ Contact with animals
History of:	□ Liver disease □ G6PD deficiency □ Seizure □ Anxiety or Depression □ Motion sickness □ Immune compromising disease □ Immune compromising medication

Are there other questions or concerns today? If so, please explain:

When finished, please return to front desk or medical staff.