Giant Food Pharmacy Travel Intake Form (revised 12.1.23)

Patient Last Name: _____	**Date of Birth (MM/DD/YYYY): _____**
Patient First Name:_____	**Age: _____**
Patient Middle Name: _____	**Gender: _____**

List all medications you are currently taking:

List all medical conditions:

Date of Departure:	**Date of Return:**

Travel Destinations (List Countries and cities):

Do you have a stop or layover greater than 12 hours in another country? Yes ☐ No ☐

If "Yes", list countries you have a layover in:

Purpose of Travel (Circle all that apply):

Aid/Volunteer Business Cruise (ship) Religious Study abroad Visit Family/Friends

Other: _____

What type of areas will you be visiting? (Circle all that apply):

Cities Countryside Desert Jungle Lakes/Rivers Mountains Plains Resorts

Other: _____

What type of activities will you be doing? (Circle all that apply):

Boating Hiking/camping Mountain climbing Safari Scuba diving Swimming

Other: _____

Will you be at altitudes of 8,000 feet or greater during your trip (excluding flights)? Yes ☐ No ☐

Do you have specific paperwork the pharmacist must complete for you? Yes ☐ No ☐

*****************************PHARMACIST USE ONLY SECTION BELOW ***********************************

Vaccines recommended: _____

Referral to P360: Yes ☐ No ☐

Over-the Counter medications recommended: _____

Other recommendations: _____

Pharmacist Name: _____ **Date**: _____

Pharmacist Signature: _____ **NPI**: _____