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PRE-TRAVEL CONSULTATION

Name:	DOB:	Age:	Gender: M / F
Address:			
		Phone:	
Email:			
Emergency Contact:		Phone:	
ltinerary			
Destinations:			Urban / Rural
Dates of Travel:			
Reason for Travel:			
Modes of Transportation:			
Potential Activities:			
Prior Travel Experience:			
Location(s):			
Malaria Prophylaxis used:			
Altitudes above 6,000ft:			
Illness(es):			
Past Medical History / Special Condition	ns / Recent Surgerie	s (Last 6 months)	:

Medications (please include dosing schedule):		Allergies:	
Vaccination History:	Are your childhood immunizations complete?	yes / no	
Personal Safety Meas	sures:		
	g barefoot, swimming in freshwater, excessive alco	hol use, high crime areas,	
personal protective me netting, being outside a	buddy with you, use sunscreen, use condoms (if se asures to avoid insect bites (long sleeve clothing spat dusk and dawn), take your medications as prescricounter meds and first aid items	prayed with DEET, mosquito	
Signature	Name (Print)	Date	