International Travel Health Clinic

You must remain in the clinic for 20 minutes following any vaccination.

Date: ___ / ___ /_____ (MM/DD/YYYY) MR #: _____

Health insurance #:_____

PATIENT INFORMATION (To be completed by the traveler)

Gender: Male Female Date of birth: ____ / ____ /_____ (MM/DD/YYYY)

Last name: _____

First name: _____

Street: _____ City: _____ STATE: _____

Country: _____ Postal code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____

Weight (if under 18 yrs): _____ lbs kg

In what country were you born? _____

If not in US, at what age did you leave your country of birth? _____

Company: _____ Job title: (?student)_____

Emergency contact: _____ Phone: _____ Relationship to you: _____

MEDICAL INFORMATION Do you currently have a fever or an active infection? Yes __ No __ (At time of this visit)

Do you have (or have you had) any of the following medical conditions?

___ Chronic or significant medical condition (specify)

i _____ ii _____

iii _____ iv _____

_ Seizures or convulsions

_ Immunosuppression/impaired immune system

_ Heart disease

_ Depression
_ Anxiety
_ Psoriasis
_ Thymus disease
_Inflammatory bowel disease
_ Diabetes
_ Respiratory (lung) conditions
_ Liver disease
_ Coagulation disorder
_ Other: _____

Are you taking any of the following medications?

_ Anticonvulsants
_ Antidepressants
_ Anticoagulant / Warfarin / Coumadin
_ Chemotherapy
_ Steroids (prednisone) Immunosuppressive drugs
_ Anti-viral medication (HIV, other)
_ Other: _____
_____
_____
_____
_____

Are you allergic to any of the following?

_Eggs (describe reaction): _____
_Food (describe reaction): _____
_Wasp/Insect bites
_Latex
_Thimerosal or Aluminum
_Neomycin
_Sulfa, Sulfamycin, Bactrim, Septra
_Penicillin
_Tetracyclines
_Formaldehyde or Phenol
_Other: _____

WOMEN ONLY

Are you pregnant?

Yes___ # of weeks: _____
No____ - Are you planning to become pregnant within 3 months? Yes
No____

Are you breastfeeding? Yes___ No___

Do you have any concern(s) regarding your period while on this trip?
Yes____No____

ITINERARY Departure date: ___ / ___ /_____ (DD/MM/YYYY)
Duration of trip: ___ days ___ weeks ___ months
Countries to be visited:

	Duration in urban areas	Duration in rural areas
1		
2		
4		
5		
6		
7		
8		
9		

Purpose of trip:
___ Pleasure/holiday
___ Visiting family/friends
___ Adoption
___ Education/study/summer camp
___ Volunteer work
___ Religious visit
___ Business (specify type of work):
_____
___ Other: _____
Where will you be staying?
___ 1st class hotel, resorts or cruise ship
___ Budget hotels and/or hostels
___ Inns / B&B
___ Camping
___ Company lodge
___ Family/friends
___ Other: _____
Possible activities:
___ Healthcare activities
___ Volunteer/humanitarian activities
___ Activities involving contact with animal
___ Veterinary activities
___ Wilderness activities/extreme sports

___ High altitude activities/climbing
___ Rafting/water sports
___ Underwater diving
___ Safari
___ Jogging, running, bicycling
___ Other: _____
_____

IMMUNIZATION HISTORY

___ I have not had any vaccinations in the past 10 years

Date of Last Dose

___ Cholera (Dukoral)

___ DT (Diphtheria/ Tetanus)
___ DTaP (Adacel)
___ DTP (Dipht./Tet./Polio)
___ Hepatitis A
___ Hepatitis B
___ Hepatitis A&B combo
___ Hepatitis A/Typhoid combo
___ HPV (Gardasil, Cervarix)
___ Influenza (seasonal/H1N1)
___ Japanese encephalitis
___ Mantoux test (PPD)
___Meningitis –Menactra/Menamune
___ MMR
___ Polio
___ Pneumococcal
___ Rabies
___ TBE vaccine
___ Typhoid fever
___ Yellow fever
___ Zoster (shingles)
___ Other: _____

Have you ever had an adverse reaction to a vaccine?
Please specify:

_____

_____

Have you taken malaria prophylaxis previously?
Please specify: _____

_____

Did you have an adverse reaction to any malaria medications?
Please specify: _____

_____

I declare that all the information provided on this form is accurate to the best of my knowledge and I understand that any false information could be detrimental to my health.
Signature: _____ Date: ___ / ___ /_____
(MM/DD/YYYY)
Note: Most vaccines are generally well tolerated; however, you may experience some soreness, redness and swelling at the injection site. Other adverse reactions may include headaches, fever, fatigue, and muscle pain. As with any vaccine, an allergic reaction or anaphylactic response could occur.