Patient Registration: Travel Immunization

Consultation Fee required

(Complete form online, print and bring with you to your appointment)

Patient's Name _____ Birthdate _____

Address _____ City/ZIP _____

Home Phone _____ Business Phone _____ Cell Phone _____

Social Security Number _____

Who is your family physician? _____ Phone _____

Itinerary

Departure Date _____ Return Date _____

What is the purpose of your travel plans? ❑ Business ❑ Vacation ❑ Student ❑ Missionary ❑ Other _____

Please list countries in order of date to be visited:

1. Country _____ Length of Stay _____ ❑ Rural ❑ Urban
2. Country _____ Length of Stay _____ ❑ Rural ❑ Urban
3. Country _____ Length of Stay _____ ❑ Rural ❑ Urban
4. Country _____ Length of Stay _____ ❑ Rural ❑ Urban

Please check all that apply to your travel plans:

❑ Major resort hotels ❑ Cruise ships ❑ Camping ❑ Rural Travel at any time ❑ Caving
❑ Staying with a family ❑ Small hotels ❑ Safari ❑ Youth Hostel ❑ Other _____

Previous International Travel

Country_____ Year _____ Country_____ Year _____

Have you had any of the following diseases, vaccinations, or medications? Please indicate the year experienced or taken.

	Year		Year		Year
❑ Flu Vaccine	_____	❑ Measles	_____	❑ Rabies Vaccine	_____
❑ Hepatitis A	_____	❑ Meningococcal	_____	❑ Rubella	_____
❑ Hepatitis B	_____	❑ Mumps	_____	❑ Tetanus Vaccine	_____
❑ Immune Globulin	_____	❑ Pneumococcal Vaccine	_____	❑ Typhoid Vaccine	_____
❑ Japanese Encephalitis Vaccine	_____	❑ Polio Vaccine	_____	❑ Yellow Fever Vaccine	_____
❑ Malaria Drug	_____				

Have you had any adverse reactions to any immunizations? ❑ NO ❑ YES

If yes, what kind of reaction? _____

Have you ever had a skin test for Tuberculosis? ❑ NO ❑ YES –Year _____

Have you ever fainted from an injection or blood draw? ❑ NO ❑ YES

Medical History

Are you allergic to any of the following? ❑ **NONE**

❑ Eggs ❑ Feathers ❑ Gelatin ❑ Sunlight ❑ Yeast ❑ Bee Stings ❑ Molds

❑ Grasses ❑ Penicillin ❑ Neomycin ❑ Sulfa ❑ Gentamicin ❑ Streptomycin ❑ Sulfites

❑ Aluminum ❑ Formaldehyde ❑ Mercury (thimerosal) ❑ Others? _____

Are you sick, taking aspirin, or have a high fever (101° F or above) ❑ NO ❑ YES

Do you have any medical conditions such as diabetes, heart or lung disease? ❑ NO ❑ YES

Are you being treated for cancer, or any other malignant disease? ❑ NO ❑ YES

Do you have a history of anemia or other blood disorder? ❑ NO ❑ YES

Do you have a history of deficiency of the immune system? ❑ NO ❑ YES

Do you have or have you had psoriasis? ❑ NO ❑ YES

Have you ever had epilepsy / seizures? ❑ NO ❑ YES

Have you ever experienced a psychiatric disorder or other serious mental health issues? ❑ NO ❑ YES

Are you on steroids, prednisone, or cortisone for any reason? ❑ NO ❑ YES

Have you ever been told that you have Guillian-Barre or a problem or illness affecting your brain or nerves? ❑ NO ❑ YES

Have you had a blood transfusion or a gamma globulin shot in the last three months? ❑ NO ❑ YES

Does anyone in your household have a cough that has lasted longer than three weeks? ❑ NO ❑ YES

Are you pregnant or trying to become pregnant? ❑ NO ❑ YES

List current medications you are taking (including birth control)**:**

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_____

_____

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