Please fill out the information below so we can better serve your travel needs. Thank you.

1. General Patient Information:

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Home Phone:	Cellular Phone:	Last 4 of your SSN (optional)
Date of Birth: ___/___/___	Male □ Female □	Age:
Employer/Company Name:	Occupation:	E-Mail (optional):
Insurance Carrier:		

2. Screening Questionnaire for Adult Immunization:

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Are you sick today?	□	□	□
2. Have you had a fever in the past 48 hours?	□	□	□
3. Do you have allergies to medications, food, or any vaccine?	□	□	□
4. Have you ever had a serious reaction after receiving a vaccination?	□	□	□
5. Have you ever fainted after receiving an injection or giving blood?	□	□	□
6. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	□	□	□
7. Do you have cancer, leukemia, AIDS, myasthenia gravis, psoriasis, problems with your thymus, or any other immune system deficiency?	□	□	□
8. Do you take cortisone, prednisone, other steroids, anticancer drugs, medications that change your immune system, medications for psoriasis or autoimmune diseases (i.e. lupus, rheumatoid arthritis), or have you had radiation treatments?	□	□	□

9. Have you had a seizure, brain infection, brain tumor, other brain problem, or other nervous system problem?	□	□	□
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	□	□	□
11. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	□	□	□
12. Have you received any vaccinations in the past 4 weeks?	□	□	□
13. Have you ever been told that you cannot receive vaccinations?	□	□	□

Did you bring your immunization record card with you: YES □ NO □
It is important for you to have a personal record of your vaccinations. If you do not have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all of your vaccinations on it.

3. Other Information:

1. How did you hear about us? Employer □ Physician □ Friend □ Web □ Other □

2. Would you like your vaccine information forwarded to your physician? Yes □ No □

Physician's Name: _____ Office Phone #: _____ Office Fax #: _____

Physician Address:_____

4. Itinerary

Please list, in order, the countries you will be traveling to:
(If you have an itinerary with you, skip this section and a copy can be made)

Country	Locations/Cities	Dates	# Days
1.			
2.			

1. Please list any transit countries and cities: _____

2. Will your travel take you to rural destinations? Yes □ No □

Accommodations
(Check all that apply)

Purposes of Travel
(Check all that apply)

□ College dormitory	□ Resort	□ Adoption	□ Research
□ Compound	□ Safari	□ Business	□ Volunteer agency
□ Cruise ship	□ Small Hotel	□ Field Work	□ Teaching
□ Foreign home	□ Staying with family	□ Foreign study	□ Outdoor Activities
□ Hostel	□ Tented camp	□ Medical related	□ Vacation
□ Major Hotel	□ Air conditioning		
□ Non-air conditioned	□ Rural		
	□ Urban		

5. Travel and Vaccination History

1. Have you ever traveled outside of the United States? Yes □ No □

Previous destinations: _____

2. Did you receive vaccinations for any of your previous travel destinations? Yes □ No □

3. Did you ever serve in the military? Yes □ No □

Previous Vaccines / Diseases

Check all you have had and/or approximate date given:
(If a childhood or previous vaccine record is available, skip this section, a copy or your record can be made).

Childhood Diseases	**Other Vaccinations**
□ Chickenpox _____	□ Typhoid vaccine _____
□ Measles/Mumps/Rubella _____	□ Yellow fever _____
Common Vaccinations	□ Japanese Encephalitis _____
□ Polio vaccine _____	□ Rabies vaccine _____
□ MMR vaccine _____	□ Twinrix vaccine _____
□ Smallpox vaccine _____	□ BCG vaccine _____
□ Tetanus/Diphtheria _____	□ Cholera vaccine _____
□ Flu vaccine _____	□ Other vaccine _____
□ Hepatitis A x 2 _____	□ TB Skin test _____
□ Hepatitis B x 3 _____	□ Immune globulin _____
□ Meningococcal _____	□ Malaria medication _____
□ Varicella vaccine _____	□ Other Medication/Treatment_____
□ Pneumonia vaccine _____	

6. General Medical Information

Please list your current and past medical conditions and the years of diagnosis:

_____

_____

Please list your surgical history and the year of the surgery:

_____

_____

1. Do you have a heart or lung problem or have had one in the past? Yes □ No □

2. Do you have severe renal or liver impairment or have had it in the past? Yes □ No □

3. Do you have any stomach conditions? Yes □ No □

4. Are you currently taking an antibiotic? Yes □ No □

7. Allergies

1. Have you ever had a life-threatening allergic reaction to any of the items listed below? Yes □ No □
Eggs □ Yeast □ Gelatin □ Streptomycin □ Polymyxin B □ Thimerosal □

2. Have you ever had an allergic reaction to any medication, including antibiotics, which caused rash, hives, or difficulty swallowing? Yes □ No □

If Yes, please list medication(s) and type of reaction you had: _____

8. Medication

Please list ALL medications you are currently taking and reason for each. Include occasional use and over-the-counter-drugs.

Drug	Reason for Use
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Others:_____

I certify that the above information is true to the best of my knowledge.

_____ _____
Signature Date

9. Counseling

I would like the following specific information by my doctor (please check the box); counseling on topics will depend on the country of travel and the duration of travel:

□ Food and Water Safety
□ Personal and Transport Safety
□ Seeking Medical Care While Abroad
□ Precautions Around Animals
□ Documentation While Traveling
□ Mosquito and Insect Precautions
□ Adventure and Outdoor Activity Precautions
□ Resources for Traveler's Education
□ Blood Clot Precautions
□ Altitude Sickness
□ Heat Stroke and Dehydration
□ Sexual Precautions
□ Traveler's Diarrhea