

Name: _____ Sex: M / F Birth Date: _____ Age _____ Date: _____
 Home address: _____ ZIP _____ Home ph: () _____ Work ph: () _____
 Occupation: _____ Employer: _____ Emp. address: _____
 Emergency Contact: Name: _____ Relation: _____ Phone: _____

A. Please list IN ORDER the place(s) you will visit, approximate length of stay and what you will be doing, (vacationing, business, missionary, research, exposure to animals, health care worker).

<u>COUNTRY</u>	<u>CITY</u>	<u>DATES</u>	<u>PURPOSE FOR VISIT</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Departure from USA: _____ Returning to USA: _____
 Date and destination of most recent trip out of US: _____

B. Medical History / Chronic Conditions (list) (include eczema, immunosuppression, steroid therapy):

Allergies (including eggs, neomycin, reactions to penicillin, sulfa drugs, or other medications):

Medications (**including** pain medications, oral contraceptives, over the counter):

(Women) Date of last menstrual period: _____

C. Past immunizations (give approximate dates):

Typhoid: Oral _____	Injectable _____	Yellow Fever _____
Varicella (chickenpox): Illness _____	Vaccines #1 _____ #2 _____	BCG (tuberculosis) _____
Polio (primary series of 3 boosters) (oral) _____	(injectable) _____	Cholera _____
Rabies #1 _____ #2 _____ #3 _____		Measles (if born in or after 1957) _____
Japanese Encephalitis #1 _____ #2 _____ #3 _____		Mumps (if born in or after 1957) _____
Hepatitis A #1 _____ #2 _____		Rubella (or Rubella titer) _____
Hepatitis B #1 _____ #2 _____ #3 _____		Menomune (meningitis) _____
Hepatitis A&B Combo (Twinrix) #1 _____ #2 _____ #3 _____		Menactra (meningitis) _____
Hepatitis B Titer _____		Immune (Gamma Globulin) _____
Flu _____		
Tetanus (within 10 years) _____		
PPD (TB skin test): _____		
Lyme Vaccine #1 _____ #2 _____ #3 _____		

General Medical Information	Y	N	<i>(CLINIC USE)</i>
Have you ever fainted from having your blood drawn or from an injection?			
Have you ever had fever or any bad reaction or side effect from any vaccination? List:			
Do you or anyone you live (or work closely) with have AIDS or any other immune disorder, leukemia or cancer, had the spleen removed, or on chemotherapy for cancer?			<i>Varicella, Smallpox, MMR, oral typhoid, Rabies, Yellow fever</i>
Have you received any injection of immune globulin or any blood product during the past 12 months?			<i>Varicella, Measles vaccine, Smallpox</i>
Have you had a fever in the past 48 hours?			<i>Td, flu, Meningococcal, OPV, Pneumococcal</i>

Name: _____ Birth Date: _____ Date: _____

General Medical Information (cont.)	Y	N	(CLINIC USE)
Are you pregnant or breast feeding now or might you become pregnant or breast feed before or during this trip or in the next 3 months?			MMR, OPV, Smallpox, Varicella, Yellow fever, Doxycycline, Cipro and other antibiotics.
Do you have a low platelet count or blood clotting disorders or take blood thinners?			IM injections
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?			Mefloquin, DTaP
Do you have any stomach conditions?			Oral typhoid, Mefloquin, Doxycycline
Do you have a G6PD enzyme deficiency?			Chloroquine, Primaquine
Do you have a history of psychiatric problems?			Mefloquine
Do you have a problem with insomnia or nightmares?			Mefloquine
Do you have a problem with vaginal yeast infections?			Antibiotics
Do you have psoriasis?			Chloroquine or related components
Have you or a household member had eczema or atopic dermatitis?			Smallpox
Are you prone to motion sickness?			
Are you prone to altitude sickness?			
Have you ever had hepatitis?			
Medications Are you taking or will you be taking:			
• Quinine, quinidine, or medications for irregular heart beats?			Mefloquine
• Chloroquine, mefloquine or proguanil to prevent malaria?			Oral typhoid
• Steroids, prednisone, cortisone, or anti-cancer drugs?			MMR, Oral typhoid, Varicella, Yellow fever
• Antibiotics?			OPV
• Pepto-Bismol, antacids or oral contraceptives?			Doxycycline, tetracycline
• Aspirin?			Varicella
• Medications for emotional problems or seizures?			Mefloquine
Allergies Are you allergic to:			
• Amphotericin B?			Rabies (PCEC)
• Penicillin or Sulfa?			Diamox, Fansidar, PCN, Sulfa
• Mercury or Thimerosal?			DtaP, Td, Hib, Japanese encephalitis, Hepatitis B, IG, Influenza, Meningococcal, Rabies (RVA, RIG)
• Streptomycin, Neomycin, Kanamycin, Gentamycin?			Twinrix, Influenza (Fluvirin, Fluogen), IPV, MMR, Rabies (HDCV, PCEC), Varicella, Smallpox, PEDIARIX
• Polymyxin			Influenza (Fluvirin), IPV, Smallpox, PEDIARIX
• Sulfites			Influenza (Fluogen), Doxycycline
• Aluminum			Hep. A, Hep. B, Twinrix, COMVAX, Dtap, Td Rabies (RVA), Anthrax, Pneumococcal (PCV)
• Benethonium chloride?			Anthrax
• 2-phenoxyethanol?			Hep. A (Havrix), Hep. A/B (Twinrix), IPV, DtaP (Infanrix, PEDIARIX)
• Bee stings or history of hives or urticaria?			Japanese encephalitis
• Yeast			Hep. A, Hep. A/B (Twinrix), PEDIARIX
• Eggs			Influenza, Rabies (PCEC), Yellow fever, MMR
• Are you hypersensitive to gelatin?			Varicella, Japanese encephalitis, MMR, DtaP, Yellow fever, Rabies (PCEC), Influenza (Fluzone), OPV
• Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formaldehyde?			IPV, Meningococcal, Typhoid, Rabies, DtaP, Pneumococcal (PPV), Anthrax, Smallpox
• Glycerin or chlortetracycline?			Smallpox

Any "problem" listed above may be a contraindication or merely a precaution that warrants further discussion and is not considered to be all inclusive.

The above information is correct to the best of my knowledge. I understand that some vaccines can cause serious or deadly illness when administered to some one infected with HIV, immunosuppressed, or pregnant. I have received written immunization information, all questions have been answered to my satisfaction and I give my consent to receive these immunizations

Name of Parent or Legal Guardian if patient is a minor _____

Patient (or Legal Guardian) Signature **X** _____ Date _____ Pg.2