

PLEASE BRING ALL YOUR IMMUNIZATION RECORDS WITH YOU TO YOUR APPOINTMENT

Traveler Information			
First Name:		Last Name:	
Date of Birth:		Date:	
(MM/DD/YY) <input type="checkbox"/> Male <input type="checkbox"/> Female			
Reason for travel: <input type="checkbox"/> Vacation <input type="checkbox"/> Business <input type="checkbox"/> Volunteer <input type="checkbox"/> Visiting friends/family <input type="checkbox"/> Other: _____			
Accommodations: <input type="checkbox"/> Hotel <input type="checkbox"/> Cruise Ship <input type="checkbox"/> Private Home <input type="checkbox"/> Back Packing <input type="checkbox"/> Caving <input type="checkbox"/> Other: _____			
Itinerary			
Trip Departure Date:		Trip Return Date:	
Please list in chronological order the Cities and Countries you are scheduled to visit, including layovers:			
Country	Cities	Arrival Date	Departure Date

Medical History	Yes	No
1. Do you have any allergies to medicines? If yes, please list	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had an allergic reaction to an immunization? If yes, to which one	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies to eggs/chicken/protein?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies to latex?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever fainted from an immunization or blood draw?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received any immunizations in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you pregnant or planning pregnancy soon? When was your last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had cancer, leukemia, HIV, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been treated with chemotherapy or radiation treatment? If so, when	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been treated with medications that weaken the immune system? If so, when	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a thymoma/thymectomy/splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

Please list all your medical conditions	Please list all the medications that you are currently taking including over the counter medicines: