



Patient Information Form

Last Name: _____ First Name: _____ DOB: _____
 Age: ____ Sex: ____ Address: _____ City/State: _____ Zip: _____
 Telephone: _____ Email (for vaccine reminders): _____
 Occupation: _____ Employer: _____
 How did you hear about us? _____
 Name of MD/NP/PA: _____ City: _____

Would you like us to notify your primary care provider about the vaccines you received? Yes No

Travel Departure Date: _____ Return Date: _____

Countries to be visited (in order, including flight connections)	Length of Stay

Reason for trip: Business Tourist Student Mission Other: _____

Are you planning to travel outside of urban areas? Yes No

Are you planning to go hiking, camping or backpacking? Yes No

Accommodations: Hotel Private home Hostel Dorm/barracks Cruise Other: _____

What are YOUR top 3 concerns about this trip?

Yellow Fever <input type="checkbox"/>	Personal safety <input type="checkbox"/>
Malaria <input type="checkbox"/>	Road accidents <input type="checkbox"/>
Diarrhea <input type="checkbox"/>	Rabies <input type="checkbox"/>
Dengue/Chikungunya <input type="checkbox"/>	Sexually transmitted infections <input type="checkbox"/>
Vaccine side-effects <input type="checkbox"/>	Other: _____ <input type="checkbox"/>

Have you had an acute illness with fever in the last 48 hours? Yes No

Have you EVER had any bad reaction from any vaccine (including fainting) Yes No

If so, please specify _____

Have you received any of these LIVE vaccines in the last 30 days? (check all that apply)

MMR <input type="checkbox"/>	Varicella (chicken pox) <input type="checkbox"/>
Yellow fever <input type="checkbox"/>	Shingles <input type="checkbox"/>

Are you allergic to: (check all that apply)

Eggs	<input type="checkbox"/>	Any foods _____
Latex	<input type="checkbox"/>	Any medications _____
Yeast	<input type="checkbox"/>	_____
Thimerosal	<input type="checkbox"/>	Environmental allergens (pets/dust)
Gelatin	<input type="checkbox"/>	_____
Bee Stings	<input type="checkbox"/>	Other _____

Have you traveled to Africa/South America in the last 30 days? Yes No
 If so, where? _____

Do you PLAN to have medical or dental procedures on this trip? Yes No

Females only:

Last menstrual period: _____	
Are you currently using birth control?	<input type="checkbox"/> Yes (Type _____) <input type="checkbox"/> No
Are you pregnant/trying to get pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If breastfeeding, is child under 9 months of age?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY

Have you EVER had: (check all that apply)

Heart disease/arrhythmia (with or without symptoms)	<input type="checkbox"/>	Thymus condition/myasthenia gravis/DiGeorge Syndrome/thymoma	<input type="checkbox"/>
Lung disease/asthma/wheezing/COPD	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Cancer/Leukemia/Lymphoma	<input type="checkbox"/>
Liver disease/hepatitis/yellow jaundice	<input type="checkbox"/>	If so please specify _____	
Kidney disease	<input type="checkbox"/>	Immune deficiency/disorder	<input type="checkbox"/>
Stomach condition/gastritis/reflux/IBS	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Depression/anxiety/psychiatric disorder	<input type="checkbox"/>	A transplant	<input type="checkbox"/>
Seizure/epilepsy/neurologic disease	<input type="checkbox"/>	If so, please specify _____	
G6PD deficiency	<input type="checkbox"/>		

Do you live/work closely with someone who has cancer/HIV/AIDS or immune deficiency? Yes No

Do you live/work closely with someone who is taking steroids/Prednisone/chemotherapy/immune modifying drugs? Yes No

Do YOU take immune modifying drugs? Yes No

If so, please specify _____

Please list current prescription and over the counter medications you are taking:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

SIGNATURE _____ **DATE** _____

IF PARENT/GUARDIAN IS SIGNING FOR A MINOR, ALSO PRINT YOUR NAME CLEARLY:



Prescription Refill Policy

CTM will fill telephone requests for prescription refills ONLY IF the patient has been seen in our office and has updated their patient information form within the past 12 months.

I understand and agree to CTM's prescription refill policy:

Full Name of Patient (please print clearly)

Signature

Date