



Patient Information Form

Last Name: _____ First Name: _____ DOB: _____

Age: ____ Sex: ____ Address: _____

City/State: _____ Zip: _____

Telephone: _____ Email (for vaccine reminders): _____

Permission for text appointment reminders: Yes No

Occupation: _____ Employer: _____

How did you hear about us? _____

Name of MD/NP/PA: _____ City: _____

Pharmacy Name/Number/Location: _____

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: _____

Any specific concerns about this trip? _____

Have you been ill with a 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"/>	Zostovax (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 preventing pregnancy?	<input type="checkbox"/> Yes (How? _____) <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/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:
