

DATE TODAY: _____

NAME: _____ D.O.B. _____ AGE: _____
 LAST FIRST M.I.

Itinerary: _____

Is your travel to: Urbanized Areas Rural Areas Urban & Rural Areas

Date of Departure: _____ Length of Trip: _____ Purpose of trip: _____

Immunizations

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have you ever fainted from having blood drawn or from an injection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a fever reaction to a vaccination? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any bad reaction/side effect from any vaccination? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you live or work closely with anyone who has AIDS, any other immune disorder or on chemotherapy for cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you received any injection of immune globulin or any blood products in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |

General Medical

- | | Yes | No |
|---|--------------------------|--------------------------|
| Do you have a medical condition that warrants maintenance? Medications or physician follow up? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a medical condition that is stable now, but may reoccur while traveling? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a fever in the past 48hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant or might you become pregnant on this trip? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had your thymus gland removed or history of myasthenia gravis, DiGeorge syndrome or Thymoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have severe thrombocytopenia (low platelet count) or bleeding disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a convulsion, seizure, epilepsy, neurologic condition or brain infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have stomach problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a G6PD deficiency? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have renal impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a hepatitis infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of psychiatric problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a problem with strange dreams or nightmares? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have psoriasis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have problems with vaginitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you prone to motion sickness? | <input type="checkbox"/> | <input type="checkbox"/> |

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Allergies	Yes	No	Please list any drug allergies: _____ _____ _____ _____ _____
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	
Mercury (Thimersol)	<input type="checkbox"/>	<input type="checkbox"/>	
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	
Grasses	<input type="checkbox"/>	<input type="checkbox"/>	
Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	

Previous Vaccinations/Diseases	Date	Previous Vaccinations/Diseases	Date
Hepatitis A	_____	TB Skin Test	_____
Hepatitis B	_____	Twinrix	_____
Influenza	_____	Tetanus/Diphtheria	_____
Japanese Encephalitis	_____	Typhoid Injectable	_____
Meningococcal	_____	Typhoid Oral	_____
Measles	_____	Yellow Fever	_____
Mumps	_____	Polio	_____
Rabies	_____	Pneumococcal	_____

PLAN

BP: _____ **Temperature:** _____ **Height:** _____ **Weight:** _____

Hepatitis A	_____	Meningococcal	_____	Polio	_____
Hepatitis B	_____	Measles	_____	Rabies	_____
Influenza	_____	Mumps	_____	TB Test	_____
Japanese Encephalitis	_____	Pneumococcal	_____	Td/Tdap	_____
Twinrix	_____	Typhoid Oral	_____	Typhoid Injection	_____

Malaria
 Malarone# _____ Chloroquine# _____ Doxyclycline# _____ Lariam# _____

Antibiotic
 Azithromycin# _____ Ciprofloxacin# _____ Other: _____

Teaching Checklist:

_____ Air Travel/Jet Lag	_____ Diabetes issues	_____ Insect Precautions
_____ Altitude Sickness	_____ Malaria rx information	_____ Safety Issues/STD
_____ Food/Water Concerns	_____ Marine issues	_____ Sunscreen
_____ Dengue Fever	_____ Pregnancy Issues	_____ Checklist/What To Take
_____ Country handouts	_____ Rabies	_____ Diarrhea Symptoms and tx