

8285327533



## Travel Immunization Questionnaire

If you have questions, please discuss them with the nurse.

| First Name   | Date of Birth: MM/DD/YY Gender:                                       |
|--|---|
|  | / / O Male O Female   |
| Last Name  | For Office use only: CAIR Number                                      |
|  |   |
|  |   |
| Trip Departure Date  Trip Return Date  Trip Return Date  | Medications List all medications you are currently taking:            |
| List all the countries you plan to visit:  |   |
|  | 2.  |
|  | 3.  |
| Past/ Current Medical History  | 4.  |
| Do you have any medical problems? O Yes O No   |   |
| If yes, please list all your medical conditions:   | 5.  |
|  | 6.  |
| 2.   | 7.  |
| 3.   | Have you ever been treated with:                                      |
| 4.   | Chemotherapy or radiation therapy (i.e., for cancer)? O yes O No      |
| 5.   |   |
| Are you pregnant or planning a pregnancy soon?   | If yes, when?   |
| O Yes  | O No Medications that weaken the immune system (see list)? O Yes O No |
| Do you need more space for your medical problems or medications?   |   |
| Allergies  |   |
| Have you ever had an allergic reaction to an immunization? O $^{\mathrm{Yes}}$ O $^{\mathrm{No}}$ If yes, to which one?  |   |
| Medication Allergies: O Yes O No If yes, to what   | medicine(s)?  |
| Other Allergies: Eggs/Chicken/Protein OOOO   | Gelatin: O O Latex: O Yes O No  |
| Vaccination history: have you had any of the following vaccines? If yes, please fill in bubble and write in date the vaccine was given - if you don't know the exact date, please estimate the month and year. |   |
| O Hepatitis B O Hepatitis B  | O Twinrix (Hep A & B)   |
| O Tetanus/Diptheria/Pertussis (Td/Tdap) O Chickenpox/Shingles  |   |
| O Measles/Mumps/Rubella (MMR) O Yellow Fever   |   |
| O Meningitis (MCV4/Menactra) O Ty  | phoid O Polio   |
| O Other  |   |