



TRAVEL ADVISORY AND IMMUNIZATION CLINIC

15005 Shady Grove Rd., Suite 450
Rockville, Maryland 20850
Office: (301) 738-6420 · Fax: (301) 738-2215

NAME: _____ SSN: _____ DATE OF BIRTH: _____

OCCUPATION/JOB TITLE: _____ SEX: M _____ F _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ FAX: _____

- REFERRED BY: SELF-REFERRAL
 HEALTH DEPARTMENT
 TRAVEL AGENT
 PHYSICIAN NAME: _____
 OTHER _____

I UNDERSTAND THAT THE TRAVEL ADVISORY AND IMMUNIZATION CLINIC DOES NOT ACCEPT INSURANCE REIMBURSEMENT FOR TRAVEL SHOTS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR THE TOTAL AMOUNT OF CHARGES FOR TRAVEL IMMUNIZATIONS AND SERVICES.

SIGNATURE: _____ DATE: _____

NAME: _____

DATE: _____

MEDICATIONS	LIST MEDICATIONS YOU ARE NOW TAKING	DRUG & FOOD ALLERGIES

MEDICAL HISTORYMark for current problems. Check box and indicate age when you had any of following symptoms or diseases.

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> ALTITUDE SICKNESS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LYMPHOMA | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> ANXIETY DISORDER | <input type="checkbox"/> DYSENTERY | <input type="checkbox"/> MALARIA | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS A | <input type="checkbox"/> MEASLES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEPATITIS B | <input type="checkbox"/> MOTION SICKNESS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CARDIAC DISEASE | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> MUMPS | <input type="checkbox"/> THYMUS DISORDER |
| <input type="checkbox"/> CHICKENPOX | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> POLIO | <input type="checkbox"/> OTHER _____ |

Primary Care Physician: _____

PREVIOUS OVERSEAS TRAVEL

LOCATION	DATE	LOCATION	DATE

- | | | | |
|---|------------------------------|-----------------------------|------------|
| DO YOU HAVE PRIOR U.S. MILITARY SERVICE? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |
| HAVE YOU EVER USED MALARIA PROPHYLAXIS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |
| HAVE YOU HAD A TUBERCULIN SKIN TEST BEFORE? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |
| HAVE YOU EVER HAD REACTIONS TO IMMUNIZATIONS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |
| DO YOU HAVE ALLERGIES TO EGGS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |
| DO YOU HAVE ALLERGIES TO ANTIBIOTICS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE _____ |

IF YES, EXPLAIN: _____

WOMEN ONLY

- | | | |
|--|------------------------------|---|
| ARE YOU PREGNANT? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU SUSPECT YOU MAY BE PREGNANT? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU PLAN TO BECOME PREGNANT WITHIN THREE MONTHS OF YOUR RETURN TRAVEL DATE? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| IF YES, CURRENT TRIMESTER? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 <input type="checkbox"/> 3 |
| IF YES, DELIVERY DATE? | _____ | |
| IF YES, ARE YOU CURRENTLY UNDER PRENATAL CARE BY YOUR PERSONAL PHYSICIAN? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU HAVE ANY COMPLICATIONS RELATED TO YOUR PREGNANCY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

IF YES, EXPLAIN: _____

PHYSICIAN FOLLOWING YOUR CARE: _____

DATE: _____

NAME:	DATE OF BIRTH:	AGE:
TRAVEL ITINERARY (IN ORDER)		
1.	4.	
2.	5.	
3.	6.	
DATE OF DEPARTURE:		DATE OF RETURN:
TRAVEL FOR: <input type="checkbox"/> PLEASURE <input type="checkbox"/> BUSINESS <input type="checkbox"/> ADVENTURE CHECK ALL THAT <input type="checkbox"/> MISSIONARY <input type="checkbox"/> DIVING <input type="checkbox"/> RURAL AREAS APPLY <input type="checkbox"/> CLIMBING <input type="checkbox"/> SAFARI <input type="checkbox"/> CRUISE <input type="checkbox"/> CAMPING <input type="checkbox"/> FIELD WORK <input type="checkbox"/> HEALTHCARE <input type="checkbox"/> ALTITUDE > 8000 FT <input type="checkbox"/> ECOTOUR <input type="checkbox"/> OVERSEAS TOUR OF DUTY <input type="checkbox"/> OTHER _____ _____		

FOR OFFICE USE ONLY

WT:	TEMP:	PULSE:	BP:	SEX: M F
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- | | | |
|--|---|---|
| <input type="checkbox"/> CDC/WHO RECOMMENDATIONS REVIEWED | <input type="checkbox"/> VACCINES ONLY | <input type="checkbox"/> STERI-AID KIT ISSUED |
| <input type="checkbox"/> RECOMMENDATIONS REVIEWED WITH PARENT/GUARDIAN | <input type="checkbox"/> PRESCRIPTIONS ONLY | <input type="checkbox"/> REPELLENTS ISSUED |
| <input type="checkbox"/> YF REQUIREMENTS DISCUSSED | <input type="checkbox"/> INFORMATION PACKET ISSUED | |
| <input type="checkbox"/> MALARIA RECOMMENDATIONS DISCUSSED | <input type="checkbox"/> INTERNATIONAL SHOT RECORD ISSUED | |

VACCINES RECOMMENDED:

- | | | |
|--|---|--|
| <input type="checkbox"/> GAMMA GLOBULIN | <input type="checkbox"/> M-M-R | <input type="checkbox"/> TWINRIX (HEP A / HEP B) |
| <input type="checkbox"/> HAVRIX ADULT/PED | <input type="checkbox"/> PNEUMOCOCCAL VACCINE | <input type="checkbox"/> TYPHOID/TYPHIM |
| <input type="checkbox"/> HEPATITIS B VACCINE | <input type="checkbox"/> POLIO (SALIK I.M.) | <input type="checkbox"/> TYPHOID-ORAL |
| <input type="checkbox"/> INFLUENZA VIRUS VACCINE | <input type="checkbox"/> PPD | <input type="checkbox"/> VARIVAX |
| <input type="checkbox"/> JAPANESE B | <input type="checkbox"/> RABIES VACCINE | <input type="checkbox"/> YELLOW FEVER |
| <input type="checkbox"/> MENINGOCOCCAL VACCINE | <input type="checkbox"/> TETANUS DIPHTHERIA | <input type="checkbox"/> OTHER _____

_____ |

PRESCRIPTIONS RECOMMENDED:

- Diarrhea Prophylaxis:** Bactrim Cipro Immodium Levaquin Lomotil Other _____
- Malaria Prophylaxis:** Chloroquine Doxycycline Lariam Malarone Other _____
- Mountain Sickness Prophylaxis:** Diamox Other _____
- Other Prescriptions:** Ambien Doxycycline Transcope Other _____
 Bactrim Halcion Xanax
 Ceftin Scopace Z-Pack

NAME: _____

DATE OF BIRTH: _____

MASTER IMMUNIZATION RECORD							
DATE	VACCINE	DOSE	ROUTE	LOT NO.	EXP	VIS/DATE	Signature
	HEPATITIS A	1.0cc	IM				
	HEPATITIS A	1.0cc	IM				
	HEPATITIS A	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	IMMUNE GLOBULIN		IM				
	IMMUNE GLOBULIN		IM				
	IMMUNE GLOBULIN		IM				
	INFLUENZA	0.5cc	IM				
	INFLUENZA	0.5cc	IM				
	INFLUENZA	0.5cc	IM				
	IPV (Inactivated Polio Virus)	0.5cc	SQ/IM				
	JAPANESE ENCEPHALITIS	1.0cc	SQ				
	JAPANESE ENCEPHALITIS	1.0cc	SQ				
	JAPANESE ENCEPHALITIS	1.0cc	SQ				
	MGC (A, C, Y, W 135) (Meningitis)	0.5cc	SQ				
	MGC (A, C, Y, W 135) (Meningitis)	0.5cc	SQ				
	MGC (A, C, Y, W 135) (Meningitis)	0.5cc	SQ				
	MMR (Measles, Mumps, Rubella)	0.5cc	SQ				
	Td (Tetanus Diphtheria)	0.5cc	IM				
	Td (Tetanus Diphtheria)	0.5cc	IM				
	Twinrix Hep A & B	1.0cc	IM				
	Twinrix Hep A & B	1.0cc	IM				
	Twinrix Hep A & B	1.0cc	IM				
	TY21a TYPHOID	4 cap	PO				
	TY21a TYPHOID	4 cap	PO				
	TY21a TYPHOID	4 cap	PO				
	TYPHIM	0.5cc	IM				
	TYPHIM	0.5cc	IM				
	TYPHIM	0.5cc	IM				
	VARIVAX (Varicella)	0.5cc	SQ				
	VARIVAX (Varicella)	0.5cc	SQ				
	YELLOW FEVER	0.5cc	SQ				
	YELLOW FEVER	0.5cc	SQ				

MASTER PRESCRIPTION RECORD					
DATE	PRESCRIPTION	DOSE	ROUTE	FREQUENCY	NUMBER

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