Travel Vaccination Questionnaire

Name : _____

Sex: Male Female Other (Circle One)

Date of Birth: _____

Phone: _____

Email : _____

Your Destination (countries/cities). Please include any layovers:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Dates of Trip: _____ To _____

	(Circle One)	
Purpose of your Trip?	Business	Pleasure
Are you currently treated for any medical problems?	Yes	No
Have you had a significant medical problem in the past?	Yes	No
Could you be pregnant?	Yes	No
Are you staying mostly in cities / tourist destinations?	Yes	No
Are you going to spend time above 5000 ft.?	Yes	No
Are you going to work in the foreign country?	Yes	No
Are you allergic to eggs or chicken products?	Yes	No
Have you had any hypersensitivity or reaction to vaccinations?	Yes	No
Have you had Guillain-Barre Syndrome?	Yes	No
Have you had all of your childhood vaccinations?	Yes	No

Please print, fill out, and bring this form with you.

	(Circle One)	
Have you had tetanus/diphtheria vaccination in the last 10 years?	Yes	No
Have you had measles vaccination (2 shots)?	Yes	No
Have you had polio vaccination as an adult?	Yes	No
Have you had hepatitis A vaccination (2 shots)?	Yes	No
Have you had hepatitis B vaccination (3 shots)?	Yes	No
Have you had meningitis vaccination in the past 3 years?	Yes	No
Have you had typhoid vaccination in the past 2 years (if injected), or in the past 5 years (if oral)?	Yes	No
Have you had yellow fever vaccination in the past 10 years?	Yes	No
Have you had Japanese encephalitis vaccination in the past 2 years?	Yes	No
List current or previous significant medical conditions?	Yes	No

List current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List allergies:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments:

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Vaccine Administration Questionnaire

1. Are you feeling sick today? _____
2. Do you have allergies to medications, food, eggs, of any component of a vaccine, Bocine Protein, Neomycin (Neosporin), Gentamicin, Polymyxin, Phenol, Thimerosal, or Gelatin?
   _____
3. Have you had any vaccinations in the past 4 weeks? If yes please list.
   _____
4. Have you had any serious reactions or fainted from a vaccine?_____
5. Have you ever had a seizure disorder for which you are or were on a seizure medication, a brain disorder or nerve problem like Guillian Barre Syndrome (a condition that causes paralysis)?
   _____
6. Are you 65 years or older, or do you smoke or have a chronic conditions (Such as asthma or diabetes?) _____
7. If you answered yes to question 6, have you ever had a pneumococcal or pneumonia vaccination? _____
8. Do you have a problem with your immune system, cancer, a history of AIDS, bone marrow disease, or Tuberculosis? Are you in contact with anyone who has a severely weakened immune system? _____
9. Are you taking steroids (Prednisone, Cortisone), Anti-Cancer Drugs, Chemotherapy, or have you had any radiation treatments? _____
10. During the past year, have you received blood or blood products or been given immune (Gamma) globulin? _____
11. Are you currently on home infusions, weekly injections and/or taking medications such as Remicade, Enebrel, Humira, or Kineret? _____
12. For women; are you pregnant or is there a chance you could become pregnant in the next few months? _____
13. Do you have a long term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (Diabetes), anemia, or other blood disorder?
    _____
14. For patients 18 years or younger: are you receiving aspirin therapy or aspirin containing therapy? _____
15. For patients under 5 years old receiving vaccine: Does he/she have history of Asthma or wheezing? _____

Name: _____ D.O.B. _____

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