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 HISTORY

Mark [C] for current problems. Check [☑] box and indicate age when you had any of following symptoms or diseases.

☐ALTITUDE SICKNESS	☐DEPRESSION	☐LEUKEMIA	☐RHEUMATIC FEVER
☐ANEMIA	☐DIABETES	☐LYMPHOMA	☐SCARLET FEVER
☐ANXIETY DISORDER	☐DYSENTERY	☐MALARIA	☐SEIZURES
☐ASTHMA	☐HEPATITIS A	☐MEASLES	☐STROKE
☐CANCER	☐HEPATITIS B	☐MOTION SICKNESS	☐TUBERCULOSIS
☐CARDIAC DISEASE	☐HIV / AIDS	☐MUMPS	☐THYMUS DISORDER
☐CHICKENPOX	☐HYPERTENSION	☐POLIO	☐OTHER_____

_____

Primary Care Physician:_____

PREVIOUS OVERSEAS TRAVEL

LOCATION	DATE	LOCATION	DATE

DO YOU HAVE PRIOR U.S. MILITARY SERVICE?	☐ YES	☐ NO	DATE_____
HAVE YOU EVER USED MALARIA PROPHYLAXIS?	☐ YES	☐ NO	DATE_____
HAVE YOU HAD A TUBERCULIN SKIN TEST BEFORE?	☐ YES	☐ NO	DATE_____
HAVE YOU EVER HAD REACTIONS TO IMMUNIZATIONS?	☐ YES	☐ NO	DATE_____
DO YOU HAVE ALLERGIES TO EGGS?	☐ YES	☐ NO	DATE_____
DO YOU HAVE ALLERGIES TO ANTIBIOTICS?	☐ YES	☐ NO	DATE_____

IF YES, EXPLAIN: _____

_____

_____

WOMEN ONLY

ARE YOU PREGNANT?	☐ YES	☐ NO	
DO YOU SUSPECT YOU MAY BE PREGNANT?	☐ YES	☐ NO	
DO YOU PLAN TO BECOME PREGNANT WITHIN THREE MONTHS OF YOUR RETURN TRAVEL DATE?	☐ YES	☐ NO	
IF YES, CURRENT TRIMESTER?	☐ 1	☐ 2	☐ 3
IF YES, DELIVERY DATE?	_____		
IF YES, ARE YOU CURRENTLY UNDER PRENATAL CARE BY YOUR PERSONAL PHYSICIAN?	☐ YES	☐ NO	
DO YOU HAVE ANY COMPLICATIONS RELATED TO YOUR PREGNANCY?	☐ YES	☐ 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: CHECK ALL THAT APPLY

☐ PLEASURE ☐ BUSINESS ☐ ADVENTURE
☐ MISSIONARY ☐ DIVING ☐ RURAL AREAS
☐ CLIMBING ☐ SAFARI ☐ CRUISE
☐ CAMPING ☐ FIELD WORK ☐ HEALTHCARE
☐ ALTITUDE > 8000 FT ☐ ECOTOUR ☐ OVERSEAS TOUR OF DUTY

☐ OTHER _____

FOR OFFICE USE ONLY

WT:	TEMP:	PULSE:	BP:	SEX: M F

☐ CDC/WHO RECOMMENDATIONS REVIEWED
☐ RECOMMENDATIONS REVIEWED WITH PARENT/GUARDIAN
☐ YF REQUIREMENTS DISCUSSED
☐ MALARIA RECOMMENDATIONS DISCUSSED
☐ VACCINES ONLY
☐ PRESCRIPTIONS ONLY
☐ INFORMATION PACKET ISSUED
☐ INTERNATIONAL SHOT RECORD ISSUED
☐ STERI-AID KIT ISSUED
☐ REPELLENTS ISSUED

VACCINES RECOMMENDED:

☐ GAMMA GLOBULIN
☐ HAVRIX ADULT/PED
☐ HEPATITIS B VACCINE
☐ INFLUENZA VIRUS VACCINE
☐ JAPANESE B
☐ MENINGOCOCCAL VACCINE
☐ M-M-R
☐ PNEUMOCOCCAL VACCINE
☐ POLIO (SALIK I.M.)
☐ PPD
☐ RABIES VACCINE
☐ TETANUS DIPHTHERIA
☐ TWINRIX (HEP A / HEP B)
☐ TYPHOID/TYPHIM
☐ TYPHOID-ORAL
☐ VARIVAX
☐ YELLOW FEVER
☐ 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 Diptheria)	0.5cc	IM				
	Td (Tetanus Diptheria)	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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