



# Patient Information Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_ Email \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Sex M / F Last Menstrual Period \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_

Would you like us to notify your primary care physician about the vaccines you received? Yes No

Travel Departure Date \_\_\_\_\_ Return Date \_\_\_\_\_

Countries to be visited (in order)	Length of stay

Reason for trip:  Business  Tourist  Student  Mission  Other \_\_\_\_\_

Are you planning to travel outside of urban areas? Yes No

Are you planning to go hiking or backpacking? Yes No

Accommodations:  Hotel  Youth Hostel  Private Home  Camping  Cruise  Other \_\_\_\_\_

Do you have:

- |   |     |    |
|---|-----|----|
| Heart trouble/High Blood Pressure                       | Yes | No |
| Lung Disease/Asthma                                     | Yes | No |
| Diabetes  | Yes | No |
| Skin Disease  | Yes | No |
| Mental Illness/Depression/Anxiety                       | Yes | No |
| Seizure Disorder/Epilepsy                               | Yes | No |
| A bleeding disorder and/or take anticoagulants?         | Yes | No |
| A history of Thymus Condition/Thymectomy?               | Yes | No |
| A history of an Immune Disorder, such as cancer or HIV? | Yes | No |
| Liver/Kidney Disease?                                   | Yes | No |



## Patient Information Form

Have you received a LIVE vaccine within 30 days (chickenpox/shingles/MMR)? Yes No

Have you ever had an adverse reaction to a shot? Describe \_\_\_\_\_ Yes No

Have you travelled to Africa/South America within the past 12 months? Yes No  
If so, list countries \_\_\_\_\_

Do you LIVE WITH someone who is taking Prednisone, steroids, or chemotherapy drugs? Yes No

Do you LIVE WITH someone who has cancer or HIV? Yes No

Do you plan to have medical/dental procedures overseas? Yes No

Do you take blood thinners? Yes No

CIRCLE any allergies you may have: eggs latex yeast mercury(Thimerisol) gelatin bee stings  
medicine (list) \_\_\_\_\_ other (list) \_\_\_\_\_

Medications currently taking: \_\_\_\_\_  
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**Women Only:**

Are you pregnant or trying to get pregnant? Yes No

Are you breastfeeding? Yes No

**I certify that the above information is correct**

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_