



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 | 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 |

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



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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 _____

If travelling to Thailand, have you been to Africa/South America within the past 10 years? If so, list countries _____ Yes No

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: _____

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 ____/____/____