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PATIENT'S NAME (LAST, FIRST, MIDDLE)							HOME PHONE
PATIENT'S HOME ADDRESS			APT. NO.	CITY	STATE	ZIP	BUSINESS PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	AGE	SEX	SPOUSE'S NAME			SPOUSE'S PHONE
PATIENT'S OCCUPATION		PATIENT'S EMPLOYER			PATIENT'S EMPLOYER ADDRESS		
EMERGENCY CONTACT		ADDRESS			PHONE NUMBER	RELATIONSHIP	
<b>INSURANCE:</b> Most insurance plans do not cover travel immunizations, therefore, we do not participate. We will, however, submit one courtesy claim for those covered by Blue Cross/Blue Shield of the National Capital Area only. Medicare ID# _____ Effective Date _____ BCBS NCA ID# _____ Group # _____ Subscriber _____							
Personal Physician:				Referred By:			

### MEDICAL HISTORY

#### ALLERGIES (FOOD, DRUGS, ENVIRONMENTAL FACTORS):

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

#### Do you have any of the following:

- |                           |                              |                             |                            |                              |                             |
|---------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| Psoriasis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart rhythm problems      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other psychiatric disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizure disorder/epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                            |                              |                             |

Are you at risk for immune deficiency? .....  Yes  No

Are you currently taking any medications (including over-the-counter drugs)? .....  Yes  No

- If yes, please list: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

#### TRAVEL-RELATED APPOINTMENTS:

IS YOUR TRAVEL FOR:  Business  Pleasure

Destinations: Country(s): \_\_\_\_\_

Length of Travel \_\_\_\_\_ Date of Departure \_\_\_\_\_ Will you be in Rural areas  Yes  No

#### WOMEN ONLY

Are you pregnant or are you considering trying to become pregnant during your stay abroad? .....  Yes  No

Are you breast feeding? .....  Yes  No

Name _____	Date of Birth _____		
		<b>YES</b>	<b>NO</b>
Is the person getting the vaccine:			
• sick with fever?			
• sick with vomiting?			
• sick with diarrhea?			
• allergic to eggs?			
• allergic to neomycin or streptomycin (antibiotics)?			
• had immune serum globulin within the last 3 months?			
• had an allergic reaction or illness of the brain that required medical attention or a hospital stay after receiving any vaccines?			
• had any vaccines within the last month? If so, what? _____			
• ever had a reaction to vaccines in the past, i.e. allergic reaction, high fever ( $\geq 105^{\circ}\text{F}$ ), collapse, shock, seizures?			
Has the person to be vaccinated or anyone in the household had any of the following conditions which would make him/her less able to fight infections:			
<input type="checkbox"/> cancer or leukemia?	<input type="checkbox"/> special cancer treatment such as x-rays or drugs?		
<input type="checkbox"/> drugs such as prednisone or other steroids?	<input type="checkbox"/> an inborn or inherited disease?		
<input type="checkbox"/> other _____			
Has there been any change in your health since you were last here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has there been a change in the medications? If so, list below: _____			
Comments: _____			
_____			
_____			

## FOR WOMEN ONLY

	<b>YES</b>	<b>NO</b>
1. Are you pregnant?		
2. Might you possibly be pregnant?		
3. Have you missed a menstrual period?		
4. Date of last menstrual period: _____		
5. Do you understand that you should not become pregnant within three (3) months after receiving this vaccine?		
6. Are you using birth control?		
7. If you are using birth control, what method: _____		

I understand that receiving these medications does not preclude the need for complete physical examinations by my doctor or the doctor of the person named above for whom I am authorized to make this request.

Initial \_\_\_\_\_

I have read the information on this form, or had the information interpreted to me in my language, and have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_