

Please complete this **Travel Medicine Visit Information** form and bring a copy of your planned itinerary, (i.e. flights, destinations, lodgings), and vaccination history to your visit.

Personal Information

Regarding this visit			
Name and Date of Birth:			
I need advice about malaria protection and prophylaxis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
I need advice about traveler's diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
I need an International Certificate of Vaccination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
If immunization(s) requested, please specify:			

About Your Trip

Specifics of your travel plans			
Cities and Countries to be visited:			
Trip Purpose:	<input type="checkbox"/> Business <input type="checkbox"/> Diving/Deep Sea <input type="checkbox"/> Altitude/Climbing <input type="checkbox"/> Other:	<input type="checkbox"/> Vacation <input type="checkbox"/> Adoption <input type="checkbox"/> Visiting Friends or Relatives	<input type="checkbox"/> Volunteering/Study Abroad/School <input type="checkbox"/> Church/Mission
Accommodations:	<input type="checkbox"/> Hotel/Resort <input type="checkbox"/> Camp/Tents <input type="checkbox"/> Other:	<input type="checkbox"/> Safari <input type="checkbox"/> Hostel	<input type="checkbox"/> Private Home/Residence <input type="checkbox"/> Apartment/College-type Dorm
Type of Travel:	<input type="checkbox"/> Urban <input type="checkbox"/> Guided tour <input type="checkbox"/> Other:	<input type="checkbox"/> Rural <input type="checkbox"/> Independent travel and itinerary	<input type="checkbox"/> Multiple Destinations
Date of Departure:			
Date of Arrival at Destination:			
Number of Days at Destination:			
Date Leaving Your Destination:			
Travel in Malarious Area?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure

Screening Questions for Immunization

Please explain any "yes" answers at the bottom of this section			
Are you sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you have an allergy to medication, a vaccine component or latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you ever had a serious reaction after receiving any vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you have cancer, AIDS, or any other immune system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you take prednisone, anticancer drugs or any medication that would lower your immunity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you have a seizure disorder or other nervous system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Are you pregnant or is there a chance you could become pregnant before or during your trip?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you received any vaccines in the past 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Please explain any "yes" answers above			

Signature

Please sign and date	
Signature	Date