TRAVEL ADVISORY AND IMMUNIZATION CLINIC

2301 Research Blvd. Suite 125
Rockville, Maryland 20850
Office: (301) 738-6420 • Fax: (301) 990-3534
www.travelclinicmd.com

NAME: _____ SSN: _____ DATE OF BIRTH: _____

OCCUPATION/JOB TITLE: _____ SEX: M _____ F _____

ADDRESS: _____

_____

HOME PHONE: _____ WORK PHONE: _____ FAX: _____

E-MAIL: _____

REFERRED BY:

- ☐ WEB SITE _____
- ☐ HEALTH DEPARTMENT
- ☐ TRAVEL AGENT
- ☐ PHYSICIAN NAME: _____
- ☐ OTHER _____

We accept the following credit cards: Mastercard, Visa, American Express, & Discover.
We also accept personal checks less than $200.00 with appropriate identification (Drivers license, VISA, etc.)

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 _____
HAVE YOU HAD ANY VACCINATIONS WITHIN THE LAST 4 WEEKS?	☐ YES	☐ NO	DATE _____

IF YES, EXPLAIN: _____

_____

_____

WOMEN ONLY

ARE YOU PREGNANT?	☐ YES	☐ NO	
DO 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 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: _____

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

FOR OFFICE USE ONLY

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

- ☐ CDC/WHO/TMA RECOMMENDATIONS REVIEWED
- ☐ RECOMMENDATIONS REVIEWED WITH PARENT/GUARDIAN
- ☐ YF REQUIREMENTS DISCUSSED
- ☐ MALARIA RECOMMENDATIONS DISCUSSED
- ☐ INSECT PRECAUTIONS REVIEWED
- ☐ INFORMATION PACKET ISSUED
- ☐ INTERNATIONAL SHOT RECORD ISSUED
- ☐ DISCHARGE INSTRUCTION GIVEN
- ☐ FOOD & WATER PRECAUTIONS REVIEWED
- ☐ DIARRHEA TREATMENT PLAN REVIEWED
- ☐ STERI-AID KIT ISSUED
- ☐ LIVE VACCINES CONTRAINDICATED

VACCINES RECOMMENDED:

- ☐ GAMMA GLOBULIN
- ☐ HAVRIX ADULT/PED
- ☐ HEPATITIS B VACCINE ADULT/PED
- ☐ INFLUENZA VIRUS VACCINE
- ☐ JAPANESE B ENCEPHALITIS
- ☐ MENINGOCOCCAL VACCINE
- ☐ M-M-R
- ☐ PNEUMOCOCCAL VACCINE
- ☐ POLIO (INACTIVATED)
- ☐ PPD
- ☐ RABIES VACCINE
- ☐ TETANUS DIPHTHERIA/ ☐ TDAP
- ☐ TWINRIX (HEP A / HEP B)
- ☐ TYPHOID/TYPHIM
- ☐ TYPHOID-ORAL - LIVE
- ☐ VARIVAX - LIVE
- ☐ YELLOW FEVER - LIVE
- ☐ 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 ☐ Scopace ☐ Z-Pack ☐ Other _____

NAME: _____ DATE OF BIRTH: _____

MASTER IMMUNIZATION RECORD

DATE	VACCINE	DOSE	ROUTE	LOT NO.	EXP	VIS/DATE	Patient Initials	SIGNATURE
	HEPATITIS A	1.0cc/0.5cc	IM					
	HEPATITIS A	1.0cc/0.5cc	IM					
	HEPATITIS B	1.0cc	IM					
	HEPATITIS B	1.0cc	IM					
	HEPATITIS B	1.0cc	IM					
	HEPATITIS B	1.0cc	IM					
	IMMUNE GLOBULIN		IM					
	INFLUENZA	0.5cc	IM					
	INFLUENZA	0.5cc	IM					
	IPV (Inactivated Polio Virus)	0.5cc	SQ/IM					
	JAPANESE ENCEPHALITIS	1.0cc	IM					
	JAPANESE ENCEPHALITIS	1.0cc	IM					
	MENVEO/ MENACTRA/ MGC (Meningitis)	0.5cc	SQ/IM					
	MENVEO/ MENACTRA/ MGC (Meningitis)	0.5cc	SQ/IM					
	MMR (MEASLES, MUMPS, RUBELLA)	0.5cc	SQ					
	MMR (MEASLES, MUMPS, RUBELLA)	0.5cc	SQ					
	RABIES	1.0cc	IM					
	RABIES	1.0cc	IM					
	RABIES	1.0cc	IM					
	Tdap (Tetanus/ Diphtheria/ Pertussis)	0.5cc	IM					
	Td (Tetanus Diphtheria)	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 (oral)	4 cap	PO					
	TY21a TYPHOID (oral)	4 cap	PO					
	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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