TRAVEL ADVISORY AND IMMUNIZATION CLINIC

15005 Shady Grove Rd., Suite 450
Rockville, Maryland 20850
Office: (301) 738-6420 • Fax: (301) 738-2215

NAME: ______________________ SSN: ______________ DATE OF BIRTH: __________

OCCUPATION/JOB TITLE: ______________________________ SEX: M______ F______

ADDRESS: ____

____

HOME PHONE: ______________ WORK PHONE: ______________ FAX: ______________

REFERRED BY:
- ☐ WEB SITE ____________________
- ☐ HEALTH DEPARTMENT
- ☐ TRAVEL AGENT
- ☐ PHYSICIAN NAME: ____________________
- ☐ OTHER ____________________

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: ______________

We accept: VISA, MasterCard, & American Express

- or -

Checks (for services under $200)

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

☐ OTHER ______________________________

FOR OFFICE USE ONLY

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

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

VACCINES RECOMMENDED:

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

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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					
	IMMUNE GLOBULIN		IM					
	INFLUENZA	0.5cc	IM					
	INFLUENZA	0.5cc	IM					
	IPV (Inactivated Polio Virus)	0.5cc	SQ/IM					
	JAPANESE ENCEPHALITIS	1.0cc	SQ					
	JAPANESE ENCEPHALITIS	1.0cc	SQ					
	JAPANESE ENCEPHALITIS	1.0cc	SQ					
	MENOMMUNE/ MENACTRA/ MGC (Meningitis)	0.5cc	SQ/IM					
	MENOMMUNE/ 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/ Diptheria/ Pertussis)	0.5cc	IM					
	Td (Tetanus Diptheria)	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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