

**AV Pediatrics, Allergy and Family Medicine
Travel Immunizations**

Date: _____

Name: _____ Date of Birth: _____ Sex: M / F Hm Phone: _____

Address: _____ Wk Phone: _____

_____ SSN: _____

Allergies: _____

Medications, prescription or over the counter: _____

Are you allergic to: Eggs: Y / N Thimerisol: Y / N Neomycin: Y / N Streptomycin: Y / N Bee Stings: Y / N

Are you currently being treated for cancer? Yes / No Explain: _____

Do you have a deficiency of the immune system? Yes / No Explain: _____

Do you have an **existing medical condition** such as diabetes, heart disease, asthma or lung disease, seizures, psych problems, skin problems? Explain: _____

Travel Plans

Date of departure: _____ Length of trip: _____

What **countries**, in the order in which you will visit them, will you be traveling to? How long will you be staying in each country?

Is your travel to: urban or city areas / rural or non-city areas / or both? (circle one)

What is your reason for travel? _____

Are you pregnant, suspect that you may be pregnant, or trying to get pregnant? Yes / No

Are you breastfeeding? Yes / No If pregnant, how many weeks? _____

Do you have any special questions or concerns to be answered at your appointment? _____

Have you had the measles? Y / N

Have you had the German measles? Y / N

Did you complete your DPT / Td series? Y / N

Did you complete your polio series? Y / N

Have you had 2 MMRs? Y / N

Have you had the mumps? Y / N

Have you had the chicken pox? Y / N

Last booster date: _____

Adult booster date: _____

Last MMR date: _____

IZ Dates:

Cholera _____

Hepatitis A #1 _____ #2 _____

Flu _____

Hepatitis B #1 _____ #2 _____ #3 _____

Typhoid oral / IM _____

Hib #1 _____ #2 _____ #3 _____ #4 _____

Immune Globulin _____

Japan Encephalitis #1 _____ #2 _____ #3 _____

Meningococcal _____

Rabies IM / ID #1 _____ #2 _____ #3 _____

Pneumococcal _____

Rx taken in past for malaria: _____ Side effects: _____