

CANTON CITY HEALTH DEPARTMENT ADULT TRAVEL CLINIC

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Office Phone: _____

Ht: _____ Wt: _____ Sex: M F Race: Caucasian African American Hispanic Asian Other _____

Pharmacy: _____ Phone: _____

Please **circle** if you are allergic to any of the following and fill in your allergic reaction:

ALLERGIES:

Neomycin	_____	2-Phenoxyethol	_____
Penicillin	_____	Bee Stings	_____
Quinine-Quinidine	_____	Eggs	_____
Sulfa	_____	Mefloquine	_____
Streptomycin	_____	Mercury	_____
Thimerosal	_____	Yeast	_____
Chicken	_____	Gelatin	_____
Tetracycline	_____	Polymyxin-B	_____
Alum	_____		

Other allergies and reactions to medications: _____

List any adverse reactions to any vaccines: _____

1. Are you taking or will you be taking: **Y=Yes N=No**

Medication for:

Heart Disease	_____	Antacids	_____
High Blood Pressure	_____	Antibiotics	_____
Diabetes	_____	Birth Control	_____
Emotional/Psychological Disorders	_____	Quinine-Quinidine	_____
Cancer	_____	Steroids/Prednisone	_____

2. List all prescription medications you are or will be taking and why:

3. History of Guillain-Barre Syndrome? _____

4. Fever in the last 24 hours? _____

5. **Females only: Pregnancy now or planned in the next three months?** _____

Date of last period _____

Are you currently breastfeeding? _____

6. Please **circle** if you have had any of the following:

AIDS/HIV
Chronic Lung/Asthma
Heart Rhythm Problems
Seizures/Epilepsy
Anxiety/Panic Disorder
Strange Dreams/Nightmares

Heart Attack
Immune Disease
Other Heart Disease
Hepatitis A B C (Circle Appropriate)
Fainting from Injections
Myasthenia Gravis

Clotting Disorder
Cancer/Leukemia
Stomach Disorder
Depression
Thymoma
DiGeorge Syndrome

7. During the past year, have you received a transfusion or blood products, or been given a medicine called immune (gamma) globulin? Yes No

8. Have you received any vaccines in the past 28 days? ___Yes ___No If yes, list _____

9. Please **check** if you have/live closely with anyone who has:
AIDS/HIV___ Cancer___ Immune Disorders/Suppression___

List any other medical or psychological conditions that require medicine or physician follow-up _____

Please note below any diseases you have had, with dates, if possible. Please also list vaccines you have had and their dates.

Disease Name	Had Disease (list date if possible)	Had Vaccine (list dates)
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Chicken Pox	_____	_____

Have you received at least three doses of tetanus/diphtheria (TD) in the past (this includes DPT as a child)?
Yes No

When was your last tetanus/diphtheria? _____

Have you received at least 3 doses of polio vaccine, including childhood doses? ___Yes ___No

When was your last dose of polio vaccine? _____

Date leaving the United States _____ Date returning _____

Countries in order of arrival and length of stay in each

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Reviewed By:

Nurse: _____ Date: _____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines and understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire one of these diseases. By signing this form, I acknowledge that I have received a copy of our Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history.

Date _____ Signature _____