INTERNATIONAL TRAVEL MEDICAL HISTORY FORM

Your Name:____ Date of birth:____________________ Age:_________ Gender: M F

Address:____City:________________________ZIP_____________Phone:__________________________

Your Pharmacy:_____________________________________Address:______________________________________Phone:_______________________________

Your medical doctor:_________________________________ Address:____Phone:____________________________

MEDICAL HISTORY: Please circle "yes" or "no" to the following questions **(attach additional pages if necessary):**

1. Have you ever had severe reactions to immunizations/vaccinations? Yes No If yes, please describe:____
2. Are you being treated for leukemia, lymphoma, cancer or any other malignant disease: Yes No
3. Do you have a history of deficiency of the immune system? Yes No
4. Do you had medical treatment for any blood disorder? Yes No
5. Do you have any existing medical condition such as diabetes, heart disease or pulmonary disease? Yes No If yes, please list /:describe:_____________

   ____

6. Do you have a history of kidney disease? Yes No
7. Do you have a history of psychiatric disorder? Yes No OR Severe Depression? Yes No
8. Do you have a history of seizures? Yes No
9. Are you pregnant; suspect you may be pregnant or trying to become pregnant? Yes No
10. Are you breastfeeding? Yes No

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11. Do you have any allergies to the following? (Circle all that apply)

    Eggs Neomycin Antibiotics Mercury (thinerosal) Bee Stings Streptomycin Polymyxin B

If yes, please describe the reaction:____

12. Are there any other drugs to which you have had an allergic reaction? Yes No If yes, please list and describe:____________________________________

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13. List all of the medications you are currently taking. Include medications for allergies and skin problems. ____

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14. **TRAVEL INFORMATION**: Departure date: _______________________ Return date:___________________________

15. Please indicate the countries you will be visiting (attach additional pages if necessary):

Destination	Where will you stay	Length of stay:	Rural Travel or camping
			Yes No
			Yes No
			Yes No
			Yes No

16. Please mark all the vaccines you have had including the date of vaccination:

	Date		Date		Date
❑ Typhoid injection		❑ Yellow Fever		❑ Japanese Encephalitis	
❑ Typhoid oral		❑ Meningococcal		❑ Measles/Mumps/Rubella	
❑ Hepatitis A		❑ Immune Globulin		❑ Tetanus Diphtheria	
❑ Hepatitis B		❑ Polio		❑ Rabies	
❑ Malaria drug (name of drug)				❑ Varicella (Chicken Pox	

Client Signature: ____ ***Reviewed by:*** _______________________________***Date:*** ________________