

New Patient Form

| | | | |
|---|------------|--------------------------------------|--|
| NAME: _____ | | DATE OF CLINIC VISIT: _____ | |
| DATE OF BIRTH: _____ | AGE: _____ | WEIGHT (if child under 95lbs): _____ | |
| (If patient under 18): GAURDIAN NAME _____ | | GAURDIAN DATE OF BIRTH: _____ | |
| HOME PHONE: () _____ | | OTHER PHONE: () _____ | |
| HOME ADDRESS: _____ <i>Street</i> | | EMAIL: _____ | |
| City _____ State _____ Zip _____ | | EMERGENCY CONTACT PERSON: | |
| MAILING ADDRESS: _____ <i>Street</i> | | Name: _____ | |
| City _____ State _____ Zip _____ | | Relationship: _____ | |
| Primary Physician: _____ | | Phone Number: _____ | |
| How did you hear about us? _____ | | | |

TRAVEL INFORMATION

| | | | | |
|---|-------------------------------------|---|--|--|
| Countries to be visited: *Please list in exact order of travel _____ _____ | | | | |
| Dates of travel: _____ to _____ | | Total # of days in altitude above 10,000 feet _____ | | |
| Total# Days before departure: _____ | | Total #of days out of the US: _____ | | |
| TYPE OF TRAVEL FOR THIS TRIP | <input type="checkbox"/> Urban/City | <input type="checkbox"/> Adventure | <input type="checkbox"/> Visiting family/friends | <input type="checkbox"/> Relocating |
| | <input type="checkbox"/> Rural | <input type="checkbox"/> Business | <input type="checkbox"/> Mission Work | <input type="checkbox"/> First Class Hotel |

ALLERGIES

| | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Do you have asthma? _____ | | | | | |
| | | No Yes | | | |
| | | | | No Yes | |
| • Penicillin or sulfa <i>(Diamox)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Sulfites <i>(Doxy)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Amphotericin B <i>(Rabies)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Polymyxin <i>(Afluria, Fluvirin, IPV)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Thimerosal/Mercury <i>(TdTdap-JE)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Yeasts <i>(HA/B-HPV)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Neomycin <i>(HA/B-IPV,MMRII-Rab-Var-Zos)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Gelatin <i>(Zos-YF-JE-MMR-Var-Fluzone-Rabies)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Gentamicin <i>(Var-Zos-MMRV)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Glycerin <i>(Rabies)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Eggs/Chicken <i>(Flu-YF, MMRII, Var, Rabies)</i> | <input type="checkbox"/> | <input type="checkbox"/> | • Lactose/Soy <i>(Typ-Td, Tdap-Men-Rab-PPV-IPV-Var)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Bee Stings <i>(JE)</i> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| List all addition allergies: _____ | | | | | |
| <i>IPV=Polio, HPV=Gardasil, HA/B=Hepatitis, PPV=Pneu23, JE=JapEnceph, Typh=Typhoid inject, TD=Tet-diphth, Tdap=tet,depth,pertus Zos=Zosta</i> | | | | | |

MEDICATIONS

| | | No | Yes | | | No | Yes |
|---|-----------------------------------|--------------------------|--------------------------|----------------------------|----------------------|--------------------------|--------------------------|
| Taking Quinine | <i>(Mefloquine)</i> | <input type="checkbox"/> | <input type="checkbox"/> | Taking Oral Contraceptives | <i>(Doxycycline)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Steroids | <i>(MMR, YF, MMRV, Zostervax)</i> | <input type="checkbox"/> | <input type="checkbox"/> | Taking daily Aspirin | <i>(Varicella)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Chemo | <i>(MMR, YF, MMRV, Zostervax)</i> | <input type="checkbox"/> | <input type="checkbox"/> | Taking Anti-convulsants | <i>(Mefloquine)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Antacids | <i>(Doxycycline)</i> | <input type="checkbox"/> | <input type="checkbox"/> | Taking TB Meds | | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Thinner | | <input type="checkbox"/> | <input type="checkbox"/> | Asthma Medication | <i>(FluMist)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antibiotics: Yes <input type="checkbox"/> No <input type="checkbox"/> How many days until completed? | | | | | | | |
| List any other medications: | | | | | | | |

| HEALTH ASSESMENT | NO | YES |
|---|------------------------------|--------------------------|
| Have you ever fainted (or felt light-headed) from an injection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a severe reaction to a vaccination including short of breath or hives? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had rabies or IG for rabies? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a fever in the past 48 hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a blood coagulation disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had hepatitis or yellow jaundice? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a convulsion, seizure, epilepsy, or any neurological condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any stomach conditions, e.g. ulcers? | <input type="checkbox"/> | <input type="checkbox"/> |
| | <i>(Oral typhoid)</i> | |
| Do you have an immune disorder, leukemia, or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have psoriasis, eczema, or atopic dermatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had your thymus gland removed or problems with your thymus? | <input type="checkbox"/> | <input type="checkbox"/> |
| | <i>(Chloroquine)</i> | |
| Do you have a history of Guillain Barre Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| | <i>(Influenza, Menactra)</i> | |
| Women only: | | |
| Are you pregnant, suspect you may be pregnant, or might become pregnant on this trip? | <input type="checkbox"/> | <input type="checkbox"/> |

IMMUNIZATION HISTORY

Check the vaccines you have had and the approximate date it was given, if known

ROUTINE IMMUNIZATIONS:

| Immunization | Date | Immunization | Date | Immunization | Date |
|-------------------------|------|----------------------|------|-------------------------|------|
| Tetanus/Diphtheria (TD) | | Polio | | Measles/Mumps/Rubella | |
| TDAP (Pertussis-Adacel) | | Flu | | Meningococcal | |
| Hepatitis A #1 | | Hepatitis A #2 | | Varicella (Chicken Pox) | |
| Hepatitis B #1 | | Hepatitis B #2 | | Hepatitis B #3 | |
| TwinRix (Hep A&B) #1 | | TwinRix (Hep A&B) #2 | | TwinRix (Hep A&B) #3 | |
| HPV #1 | | HPV #2 | | HPV #3 | |
| Zostavax (Shingles) | | Pnemovax 23 | | Other | |

TRAVEL IMMUNIZATIONS:

| Immunization | Date | Immunization | Date | Immunization | Date |
|--------------------------|------|--------------------------|------|--------------------------|------|
| Typhoid | | Yellow Fever | | Meningococcal | |
| Japanese Encephalitis #1 | | Japanese Encephalitis #2 | | Japanese Encephalitis #3 | |
| Other | | | | | |

VACCINATION CONSENT FORM

| <u>ADULT VACCINATIONS COMPLETED</u> Date: _____/_____/_____ | VACCINE SERIES | Accept (Initial) | Decline (Initial) |
|---|----------------|------------------|-------------------|
| <input type="checkbox"/> Hepatitis A & VIS | Dose 1, 2 | | |
| <input type="checkbox"/> Hepatitis B & VIS <input type="checkbox"/> Accelerated | Dose 1, 2, 3 | | |
| <input type="checkbox"/> Hep A/B TwinRix & VIS <input type="checkbox"/> Accelerated | Dose 1,2,3, B | | |
| <input type="checkbox"/> Influenza (Flu) & VIS <input type="checkbox"/> Shot <input type="checkbox"/> Mist | 1 Dose | | |
| <input type="checkbox"/> Japanese Encephalitis (<i>Wait 30 mins after injection</i>) & VIS | Dose 1,2 | | |
| <input type="checkbox"/> MMRII (Measles/Mumps/Rubella) & VIS | 1 Dose | | |
| <input type="checkbox"/> Meningococcal Meningitis & VIS | 1 Dose | | |
| <input type="checkbox"/> Pneumococcal (Pnemovax 23®) & VIS | 1 Dose | | |
| <input type="checkbox"/> Polio & VIS <input type="checkbox"/> Booster | 1 Dose | | |
| <input type="checkbox"/> Rabies (Pre-vaccination Series) & VIS <input type="checkbox"/> Accelerated | Doses 1,2,3 | | |
| <input type="checkbox"/> TDAP (TD with acellular pertussis) & VIS | 1 Dose | | |
| <input type="checkbox"/> Tetanus/diphtheria & VIS | 1 Dose | | |
| <input type="checkbox"/> Typhoid & VIS | 1 Dose | | |
| <input type="checkbox"/> Oral Typhoid & VIS | 4 Oral Tablets | | |
| <input type="checkbox"/> Varicella & VIS | 1 Dose | | |
| <input type="checkbox"/> Yellow Fever (<i>Wait 30 mins after injection</i>) & VIS | 1 Dose | | |
| <input type="checkbox"/> Shingles (Zostavax) (<i>≥60YRS</i>) & VIS | 1 Dose | | |
| <input type="checkbox"/> HPV (Gardasil or Cervarix) & VIS | Dose 1,2,3 | | |

(* Patient or Guardian must initial the recommended vaccine/s and Vaccine

Information Statements that they accept or decline)

I have read and understood to my satisfaction the materials provided to me including the VIS (Vaccine Information Statement) sheets for each vaccine(s) from the CDC (Centers of Disease control and prevention) that provides:

- Disease description and prevention vaccine
- Who should receive the vaccines
- Contraindications
- Common Side Effects and reactions to the vaccine
- Number of doses required for protection
- Possible Adverse Side Effect

I understand that vaccines, health precautions, insect protection and malaria preventive medications are extremely helpful, but are not a guarantee that I will not become ill as a result of my trip. I understand that vaccines and medications can in rare instances cause complications, including death. I also understand that the risk of serious harm is extremely small and that these vaccines and medications are FDA approved. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease. I also give permission for you to provide my personal health care provider with a list of the vaccines that I have received.

Print Name: _____ Patient Signature _____ Date _____

Guardian Signature (If patient < 18 years of age) _____ Date _____