Travel Vaccine Preventive Screening rev. 8/2015

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PLEASE answer the questions below by checking the appropriate response or filling in the blanks.

First Name_____ Last Name_____ Date of birth:____/____/_____

List all countries you plan to visit with approximate dates of stay:	Will you be visiting any rural areas? No___Yes___ If yes, in which countries will you travel to rural areas?:

#	Medical History			
1	*Check* if you're allergic to: nothing____ latex/rubber____ thimerasol____ gelatin____ insect bites____ eggs/chicken____ List other drug, food or vaccine allergies:			
2	List all medicines you currently take including over-the-counter **(You may attach a list to this sheet)**:			
3	*Check* if you *have a history of*: stroke___ heart attack___ diabetes___ blocked arteries in heart___ high blood pressure___ kidney disease___ chest pain___ blood clots___ COPD___ asthma___ cancer (what kind?)_____ motion sickness___ altitude sickness___ hepatitis___ myasthenia___ thymus disorder___ seizures___ psychosis___ heart arrhythmias___			
4	Do you *currently have* cancer, leukemia, lymphoma, HIV/AIDS, an organ transplant, or any other immune system problem?	No___	Yes___	don't know___
5	List any other active medical problems you *now have*:			
6	What year was your ***last vaccination for***: yellow fever_____ polio_____ typhoid_____ flu_____ pneumonia_____ meningitis_____ hepatitis A_____ tetanus_____ hepatitis B_____			
7	List any vaccines you have taken in **the past 4 weeks**?	no vaccines___		flu shot only___
8	Have you recently had or will you soon have chemotherapy, radiation therapy, steroids (e.g., prednisone) or drugs to lower immune response (e.g., humira, methotrexate, remicade, enbrel)?	No___	Yes___	don't know___
9	Have you ever taken anti-malaria medicine? No____ Yes____ If yes, list the names of all you have taken with side effects if any:			
10	Ladies: Are you pregnant now or likely to be in the next 3 months ?	No___	Yes___	don't know___
11	Do you have a fever or any active symptoms today?	No___	Yes___	don't know___

Sign here: _____ Date signed:_____

STAFF ONLY WRITE BELOW THIS LINE~~STAFF ONLY WRITE BELOW THIS LINE

BP _____ / _____ Pulse _____ PO2 _____ Temp. _____ °F Vitals taken by _____

GENERAL ___ NAD ___ Acutely ill ___Chronically ill **RESPIRATORY** ___ Nl Resp. effort ___ No rales ___ No wheezes or rhonchi **CARDIOVASCULAR** ___ RRR ___ No M/R/G ___ /6 SEM @ _____ ___ No Carotid bruits	**ABDOMEN/ G.I.** ___ Nl sounds/Nontender ___ No masses or HSM **NEUROLOGIC** ___ A & O ___ Nl gait ___ CN II-XII Intact ___ Nl DTRs & strength **EXT.** ___ No C/C/E **SKIN** ___ No rashes	**I RECOMMENDED**	**Pt. agreed?**	**ADDED H & P / COMMENTS**
		___ antimalarial Rx	yes__ no__	
		___ motion sickness Rx	yes__ no__	
		___ altitude sickness Rx	yes__ no__	
		___ DVT precautions	yes__ no__	
		___ anti-diarrhea Rx	yes__ no__	
		___ Rx anti-viral for flu	yes__ no__	
		___ mosquito protection	yes__ no__	
		___ food/water caution	yes__ no__	

Vaccines to be given today ONLY IF CHECKED below:	**Other prescriptions, advice given or future vaccinations scheduled:**
___yellow fever ___hep. A ___typhoid ___hep. B **___tet/dipth ___adacel other_____**	_____ _____

M.D./ARNP/P.A. Signature: _____ Date: _____