Affix Patient MRN Sticker

Comer Pediatric Family Travel Clinic Intake Form

Name____Age_______Sex_______
Address____
City________________________________ State ___________Zip___________
Home Phone____________________ Cell Phone ________________________
Date of Birth____________________

Did patient bring copy of vaccination records with them? YES / NO

What other household members will be traveling with patient?
Parent: YES / NO
Other Child: YES / NO

Will these household members be bringing a copy of vaccination records with them to visit?
YES / NO

PLANNED ITINERARY—in EXACT ORDER of travel:
Departure Date____________________ Return Date (approximate)______________

Country	City	Length of Stay	Rural Travel: Yes or no

ACCOMMODATIONS: (**Check all that apply.**)
____Resort ____Cruise Ship ____Private Home ____Camping
____Dormitory ____Small hotels ____Youth Hostel
Other(please provide details on how rustic accomodations will be and which location)_________

PURPOSE OF TRAVEL: **(Check all that apply.)**
____Business ____Biking/ Back country Hiking ____Volunteer Organization
____Vacation ____Diving ____Safari ____Foreign Study ___Visiting Family
____ Missionary ___Contact with animals Other______________________

Traveling to High Altitudes? Yes/No

For persons of childbearing potential, any possibility of pregnancy? Yes/No

CURRENT MEDICATIONS: Are you taking any medications? (Circle) No/Yes
List all current medications and dosage schedules (include oral contraceptives and over-the-counter drugs):

Drug Name:	Dose	Route	Frequency	Reason

Past Medical History

Please check the following medical conditions that you have currently or had in the past:

Question	Yes	No	Question	Yes	No
Do you have heart problems? If yes what:__________________	□ Yes	□ No	Have you any neurologic disease (seizures)? If yes what:__________________	□ Yes	□ No
Do you have a cardiac arrhythmia or irregularity? If yes what:__________________	□ Yes	□ No	Do you have liver disease? If yes what:______________	□ Yes	□ No
Do you have high blood pressure or take high blood pressure medicine? If yes what:__________________	□ Yes	□ No	Have you had Altitude Sickness? If yes when:_______________	□ Yes	□ No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy? If yes what:__________________	□ Yes	□ No	Do you have a metabolic disorder (like diabetes or thyroid)? If yes what:__________________	□ Yes	□ No
Do you have breathing problem? If yes what:__________________	□ Yes	□ No	Do you have an active nerve disorder? Do you have a history of Guillian-Barre Syndrome?	□ Yes	□ No
Do you have any skin diseases? If yes what:__________________	□ Yes	□ No	Are you prone to motion sickness?	□ Yes	□ No
Do you or your child have any sleeping issues ? If yes what:__________________	□ Yes	□ No	Do you have tuberculosis, or tested positive for tuberculosis?	□ Yes	□ No
Do you have Gastrointestinal issues? If yes what:__________________	□ Yes	□ No	Do you have a history psychiatric disorders? If yes what:__________________	□ Yes	□ No
Have you ever traveled internationally? If yes, did you get ill? □ **Yes** □ **No**	□ Yes	□ No	During the past three (3) months have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	□ Yes	□ No

Are you allergic reaction to any drug, medication or food? □ **Yes** □ **No** □ **If yes, what are you allergic to?** ____ ____ ____	Do you have any condition/medication which suppress the immune system? (For example, HIV infection, spleen removed, therapy for cancer or autoimmune disease, organ transplant) □ **Yes** □ **No** **If yes, please list** ________________________
Have you had any prior reaction to any vaccines or components vaccine or vaccine component (thimerosol or mercury or any preservative)? that you may have received in the past? □ **Yes** □ **No** If yes what:__________________	Other medical conditions? Please list: ____ ____ ____ ____________________________

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Immunization History

Fill in dates or attach PDF/File to email

IMMUNIZATIONS	DATES OF IMMUNIZATION	INFO
TETANUS, TD, DPT, Tdap	1._____2._____3._____4._____ 5._____6._____7._____	Good for 10 years, 5 for severe wounds- if had primary series Need one time Tdap as adult to prevent pertussis (whooping cough)
POLIO by injection or oral	1._____ 2._____ 3._____ 4._____	May need adult booster after primary series depending on travel
MMR measles mumps rubella	1._____ 2._____	first MMR should be given after 1st birthday
Chicken pox or VARICELLA	1._____ 2.*_____or Disease ____ (Give vaccine dates OR date of disease)	*For adults booster given after 4-8 weeks
HEPATITIS A	1._____ 2.**____	** Booster after 6-12 months; Good for 20 years
HEPATITIS B series	1._____ 2._____ 3._____	
MENINGOCOCCAL	1._____ 2._____	
PNEUMOCOCCAL		
TYPHOID injection or oral?		Booster needed after 2 – 5 years
YELLOW FEVER		Booster needed after 10 yrs.
RABIES series	1._____2._____3._____ (pre-exposure)	Post exposure booster days 0 & 3 If animal bite and no pre-exposure prophylaxis hx, will need rabies immune globulin + a series of 4 rabies shots
INFLUENZA	1._____ 2._____	Annual
COVID-19 Vaccine	1._____ 2._____	
JAPANESE ENCEPHALITIS (JE-VAX or IXIARO)	1._____ 2._____	