

OVERSEAS TRAVELING IMMUNIZATION QUESTIONNAIRE

Client Name _____ Male ___ Female ___
 Address _____ Birthday _____
 City _____ State _____ Zip _____

- | | Yes | No | Specify |
|--|-----|-----|---------|
| 1. Is this patient <u>now</u> ill with something more serious than a cold? | ___ | ___ | ___ |
| 2. Does this patient have a fever over 101 degrees at present? | ___ | ___ | ___ |
| 3. Has this patient ever had a severe, local or systemic reaction to previous shots? | ___ | ___ | ___ |
| 4. Is this patient taking any medications now or being treated by a doctor? | ___ | ___ | ___ |
| 5. Does the patient have any food or drug allergies? (i.e. eggs, Neomycin, thimerosal, gelatin, polymixon B, streptomycin, sulfa, yeast, penicillin, aluminum, phenoxethanzl. | ___ | ___ | ___ |
| 6. Is this patient allergic to latex? | ___ | ___ | ___ |
| 7. Does anyone in the household have any disease that lowers the body's resistance to infection? (i.e. Chemotherapy, radiation therapy, cancer, leukemia, steroid therapy, HIV, and TB). | ___ | ___ | ___ |
| 8. Has patient been exposed to any contagious disease in the last 30 days? | ___ | ___ | ___ |
| 9. Has this patient received any vaccines within the last 30 (thirty) days? If yes please list:

_____ | ___ | ___ | ___ |
| 10. Could this patient possibly be pregnant or breastfeeding? | ___ | ___ | ___ |
| 11. Do you understand the possible side effects of these vaccines? | ___ | ___ | ___ |
| 12. Patient was given vaccine information sheets(s) to take home? | ___ | ___ | ___ |

List countries you are traveling to in order and how long you will be spending in each.

Will these areas be rural/urban? _____

 Patient Signature

 Parent or Legal Guardian