**Southeastern Center for Infectious Diseases, P.A.**

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**FULL TRAVEL/IMMUNIZATION QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age:

Additional Traveler(s):

(separate questionnaire completed for each person named above)

Address:

 Street Apt.#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Email

Home Phone: (\_\_\_\_\_\_\_\_) Other Phone: (\_\_\_\_\_\_\_\_)

Emergency Contact Name: Phone: (\_\_\_\_\_\_\_\_)

Travel for: 🞏 Work related. Employer: 🞏 Pleasure

🞏 Other (i.e., missionary, church group, etc.)

**\*\*\* How did you hear about us?** **□ Physician □ Friend □ Print Ad □ Website □ Street Signage**

Activities in any of the following areas: 🞏 spelunking 🞏 animal handling 🞏 health care

🞏 High altitude trekking 🞏 other:

Have you travelled out of the country in the past? 🞏 No 🞏 Yes, what countries?

Departure Date: Return Date:

Countries on your itinerary in the order you will be visiting:

**Country Urban Rural How long? Purpose of visit/accommodations**

🞏 🞏

🞏 🞏

🞏 🞏

🞏 🞏

🞏 🞏

🞏 🞏

**Health History**

Primary Care Physician:

Allergies to: Other allergies to food/medications:

Thimerosal 🞏 Yes 🞏 No

Neomycin 🞏 Yes 🞏 No

Yeast 🞏 Yes 🞏 No

Eggs 🞏 Yes 🞏 No

Insects 🞏 Yes 🞏 No

Gelatin 🞏 Yes 🞏 No

Current Medications (including OTC, herbal supplements): 🞏 None

**Females only (55 and younger)**

**Date of last menstrual period: Currently pregnant?** 🞏 **Yes wks. gest.** 🞏 **No**

**Method of pregnancy prevention: Breastfeeding now?** 🞏 **Yes** 🞏 **No**

**Planning pregnancy within the next few months?** 🞏 **Yes** 🞏 **No**

If you were born on OR before 1957, ever acquire infection with? 🞏 Measles 🞏 Mumps 🞏 Rubella

Have you ever been diagnosed with hepatitis A? 🞏 Yes 🞏 No

Have you ever been given a vaccination for tuberculosis called BCG? 🞏 Yes, last neg. CXR: 🞏 No

Have you ever had a TB test? 🞏 Yes 🞏 No If yes, when?

Was there a positive reaction? 🞏 Yes 🞏 No If yes, did you have CXR done? 🞏 Yes 🞏 No

What were the results of the CXR? 🞏 Negative 🞏 Positive, treatment with:

x months and treated by Dr. or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Dept.

Have you received immune globulin or a blood transfusion/blood product in the past 3 months? 🞏 Yes 🞏 No

Medical history of: 🞏 HIV/AIDS 🞏 on chemotherapy 🞏 diabetes 🞏 asthma 🞏 splenectomy

🞏 renal failure 🞏 liver disease 🞏 hypertension 🞏 bleeding disorders 🞏 seizure disorder

🞏 cardiovascular disorder 🞏 other:

**Prior Immunization History**

**Vaccination: Received vaccine before? Booster?**

 Yes Probably No Not sure Approx. date Not Sure

Hepatitis A 🞏 🞏 🞏 🞏 🞏

Hepatitis B 🞏 🞏 🞏 🞏 🞏

*Homophiles influenza (Hib)* 🞏 🞏 🞏 🞏 🞏

Immune glob (hep A) 🞏 🞏 🞏 🞏 🞏

Influenza 🞏 🞏 🞏 🞏 🞏

Japanese encephalitis 🞏 🞏 🞏 🞏 🞏

Meningococcal 🞏 🞏 🞏 🞏 🞏

MMR 🞏 🞏 🞏 🞏 🞏

Pneumococcal 🞏 🞏 🞏 🞏 🞏

Polio 🞏 🞏 🞏 🞏 🞏

Rabies 🞏 🞏 🞏 🞏 🞏

Tetanus/Diphtheria OR Tdap 🞏 🞏 🞏 🞏 🞏

Twinrix 🞏 🞏 🞏 🞏 🞏

Typhoid (oral or injectable) 🞏 🞏 🞏 🞏 🞏

Varicella 🞏 🞏 🞏 🞏 🞏

Yellow Fever 🞏 🞏 🞏 🞏 🞏

Other information/comments: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Pt. instructed to bring previous vaccination records/vaccine card

🞏 If positive PPD, instructed to bring copy of negative CXR results

🞏 If medical history of steroids/chemo/cardiac issues/etc. bring authorization to receive vaccines from PCP

🞏 Pt. requests full travel visit (we research all diseases and discuss at time of office visit, educate and provide vaccines and prescriptions) $45 office visit + vaccination fees

🞏 Informed of office visit/vaccine fees and that insurance will not be filed. Payment in full at time services are rendered.

Appointment scheduled on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM/PM

Comment(s):

Reviewed/Signed by Dr. Philbert Ford: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: