Valley Infectious Disease Associates Travel Medicine Clinic
Medical History Form

Name:_____ Date of Birth: _____

Primary Care Physician_____

(We need a copy of our record to the physician(s) you list above.)

Health Information

Are or have you:

1. Been treated for Leukemia, Lymphoma, or any malignant diseases?
   Y/N If yes please explain:_____

2. Have a history of health condition(s) such as diabetes, heart or lung disease, thymectomy, thymoma, Myasthenia Gavis, immune system, HIV infection or bleeding disorder?
   Y/N If yes please explain:_____

3. Currently taking any prescribed or over the counter medications?
   Y/N If so please explain:_____

4. Allergic to any medications, eggs, gelatin, latex, thimerosal or vaccines?
   Y/N If yes please explain:_____

5. Received blood, blood products or biological legends (ie REMICADE type medication) in the past year?
   Y/N If yes please explain:_____

6. Patient weight if under 12 years old:_____

Woman Only

1. Are you pregnant, suspect you may be pregnant or trying to get pregnant? Y/N
2. Are you breastfeeding? Y/N

Immunization History

Are you or have you:

1. Received the polio vaccine as a child?
   Y/N If so please explain:_____
2. Had a tetanus vaccine within the last 10 years?
   Y/N If so please explain:_____
3. Received other vaccines within the last 4 weeks?
   Y/N If so please explain:_____

I authorize Valley Infectious Disease Associates Travel Medicine Clinic to administer the following vaccine(s)

**** Travel CONSULTS leave blank as vaccines are TBD via the travel consult between the physician and you****

Varicella___ Shingles___ Pneumonia___ Typhoid___ HepatitisA___ HepatitisB___ MMR___ Pollo___ Yellow Fever___ Meningitis___ Tdap___ Rabies___ Japanese Encophalitis___ Hib___ Flu___

Other:_____

I understand that I will be given and must read the vaccine information sheet(s) given to me for the vaccines I will be receiving.

The nature, benefits, risks and possible side effects of the proposed vaccines have been explained to me and I have been advised of my rights to refuse such vaccines and the possible consequences of each decision.

I am aware that the vaccines(s) may not have the desired objectives and that no warranty or guarantee has been made.
Patient must sign, or patient's legal representative must sign and list relation to the patient:

Name:_____ Date:_____