

Please answer the following questions

Are you...

- Staying in Hotels? Yes No
- Visiting only urban areas? Yes No
- Staying and / or eating with local families? Yes No
- Visiting usual tourist areas? Yes No
- Utilizing non-air conditioned accommodations? Yes No
- Staying in rural areas? Yes No

Medical History

1. Do you have any known allergies? Yes No

If yes, please list _____

2. Do you have allergic reactions to eating eggs? Yes No

3. Do you have allergic reactions to antibiotics? Yes No

If yes, please list _____

4. Do you have allergic reactions to sulfa drugs? Yes No

5. Do you have an allergy to bee/wasp stings? Yes No

6. Have you ever had an anaphylactic reaction (required ER visit or Epi Pen)? Yes No

7. Do you have a history of any of the following?
- a) Seizures / epilepsy Yes No
 - b) Nightmares Yes No
 - c) Psychiatric disorders Yes No
 - d) Anxiety disorders Yes No
 - e) Immune deficiency (HIV, cancer, rheumatologic disease) Yes No
 - f) Psoriasis Yes No
 - g) G6PD Deficiency Yes No
 - h) Irregular heart beats/ cardiac arrhythmias Yes No
 - i) Any heart disease Yes No
 - j) Rheumatologic disorders (Lupus, arthritis, etc.) Yes No

k) Diseases of the Thymus Gland
(i.e. Myasthenia Gravis)

Yes No

8. Are you pregnant?

Yes No

9. Are you being treated for any medical conditions?

Yes No

If yes, please list

10. Are you currently taking any medications?

Yes No

If yes, please list

11. Routine Immunizations: Provided by your Primary Care Provider?

Yes No

Up to date?

Yes No

Have you ever had a reaction to a vaccine? If so, what happened?

Have you ever received any vaccines for travel?

Yes No

If yes, which ones and when did you receive them (please list)

Vaccine

Date

**If possible please bring your most recent immunization record
with you to your appointment or fax it back with this form.**

Signature _____

Date _____