

Travel Clinic
Office of Health Promotion & Education
Yale University Health Services
Phone (203)432-0093 Fax (203)432-0095

Name: _____ Date: _____ Phone: _____
 Address: _____ Birth Date: _____

A. Please list IN ORDER the place you will visit, approximate length of stay and what you will be doing, (sightseeing, vacationing, business, research, exposure to animals, health care worker).

	LOCATION (Countries)	CITY/RURAL	DATES	PURPOSE
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Departure from New Haven: _____ Arrival at Destination: _____ Return to USA: _____

B. Past Medical History (include eczema, immunosuppression, steroid therapy):

Allergies (including eggs, neomycin, reactions to penicillin, sulfa drugs, or other medications):

Medications (including pain medications, oral contraceptives):

Are you presently in good health (any fever or infection)? _____

Have you ever had hepatitis or been vaccinated against hepatitis? _____

Are you pregnant or do you plan to become pregnant in the next 3 months? _____

Do you live with anyone who is immunocompromised (cancer, infections)? _____

Do you have or have you been treated for a G-6-PD deficiency? _____ G-6-PD Level _____

C. Past immunizations (give dates):

DPT/Tetanus-toxoid (within 10 years)	_____
Polio (primary series of 3 boosters, oral/shots)	OPV _____ IPV _____
Measles (if born in or after 1957)	_____
Mumps (if born in or after 1957)	_____
Rubella (or Rubella titer)	_____
Cholera _____	Meningococcal _____
Immune (Gamma Globulin) _____	Plague _____
Hepatitis A #1 _____ #2 _____	Rabies #1 _____ #2 _____ #3 _____
Hepatitis B #1 _____ #2 _____ #3 _____	Typhoid: Oral _____ Injectable _____
Hepatitis B Titer _____	Varicella: Illness _____ Vaccines #1 _____ #2 _____
Influenza _____	Yellow Fever _____
Japanese Encephalitis #1 _____ #2 _____ #3 _____	Lyme Vaccine #1 _____ #2 _____ #3 _____
PPD: _____	

Past Reactions to vaccinations:

D. If you are HIV positive, please speak to the physician before receiving any vaccines!

E. Do you have any specific questions about your trip?

For office use only:	Nurse Signature: _____
	Date: _____