

Name (Last, First MI) Generation (Sr., Jr., I, II, etc)

Patient ID# (Assigned by OCHD)

DOB

Onslow County Health Department (OCHD)

Travel Clinic
Patient Questionnaire

ITINERARY. List the countries/cities you will be visiting. The United States will be your country of origin.

Table with 4 columns: Country, City, Country, City. Three rows for itinerary entries.

Leaving the United States on this date: Returning to the United States on this date:

Will the trip be (check all that apply)? [ ] Urban [ ] Rural [ ] Both

Accommodations (check any that apply): [ ] Hotel [ ] Camp/Tent [ ] Dormitory [ ] Ship [ ] Private Residence/Home

ALLERGIES / MEDICAL CONDITIONS

1. Do you have any Medicine allergies? [ ] No [ ] Yes, if yes list below.

2. Are you pregnant or contemplating pregnancy? [ ] No [ ] Yes [ ] Not Applicable

3. Are you breastfeeding? [ ] No [ ] Yes [ ] Not Applicable

4. Have you had any severe reactions to past vaccines? [ ] No [ ] Yes, if yes list below.

5. List all medications you are currently taking, either prescriptions or over-the-counter (attach list if needed):

6. Do you have any medical conditions, such as diabetes, heart disease, or lung disease? If so, explain below:

TO AVOID REPEATING SHOTS, BRING YOUR IMMUNIZATION RECORD(S)

Resources to help you locate your immunization record(s):
https://www.cdc.gov/vaccines/hcp/admin/immuniz-records.html

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**ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES, NO OR UNKNOWN**

1. Do you have sensitivity to sodium chloride, sorbitol or have been diagnosed with multiple sclerosis (MS)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
2. Are you allergic to gelatin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
3. Do you have sensitivity to yeast extract, casein, dextrose, galactose, sucrose, ascorbic acid, amino acids, lactose, or magnesium stearate?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
4. Do you have an allergy to natural latex rubber?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
5. Do you have sensitivity to protamine sulfate?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
6. Do you have an allergy to thimerosal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
7. Do you have an allergy to yeast?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
8. Do you have an allergy to neomycin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
9. Are you allergic to eggs or chicken protein?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
10. Are you allergic to processed bovine gelatin, chlortetracycline, or amphotericin B?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
11. Do you have sensitivity to phosphate or glutamate?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
12. Are you immunosuppressed due to HIV, leukemia, lymphoma, thymic disease, generalized malignancy, corticosteroid therapy, alkylating drugs, antimetabolites, or radiation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
13. Do you have a history of thymus disease, myasthenia gravis, DiGeorge syndrome or thymoma?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
14. Have you had removal of part of your intestine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
15. Are you taking sulfonamides or antibiotics?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
16. Are you currently experiencing an acute gastrointestinal illness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
17. Do you have a history of Guillian-Barre Syndrome?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
18. Have you had a past reaction to pertussis (whooping cough) vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
19. Do you have a history of a progressive neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
20. Do you have thrombocytopenia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
21. Do you desire anti-malarial medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
22. Do you desire a prescription for the treatment of Traveler's Diarrhea?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RETURN COMPLETED FORM ONE (1) WEEK PRIOR TO SCHEDULED APPOINTMENT BY:**

(910) 347-4246 (FAX)

or

Mailing/Hand Delivering to:

Onslow County Health Department

ATTN: Immunization Travel Clinic

612 College St.

Jacksonville, NC 28540