For office use only: CAIR Number

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health CARE AGENCY

Travel Immunization Questionnaire

PLEASE BRING ALL YOUR IMMUNIZATION RECORDS WITH YOU TO YOUR APPOINTMENT

Traveler Information

First Name: **Last Name:** **Date:**

Date of Birth: (MM/DD/YY) ☐ Male ☐ Female

Reason for travel: ☐Vacation ☐Business ☐Volunteer ☐Visiting friends/family ☐Other: ____________

Accommodations: ☐Hotel ☐Cruise Ship ☐Private Home ☐Back Packing ☐Caving ☐Other: ___________

Itinerary

Trip Departure Date: **Trip Return Date:**

Please list in chronological order the Cities and Countries you are scheduled to visit, including layovers:

Country	Cities	Arrival Date	Departure Date

Medical History	Yes	No
1. Do you have any allergies to medicines? If yes, please list	☐	☐
2. Have you ever had an allergic reaction to an immunization? If yes, to which one	☐	☐
3. Do you have any allergies to eggs/chicken/protein?	☐	☐
4. Do you have any allergies to gelatin?	☐	☐
5. Do you have any allergies to latex?	☐	☐
4. Have you ever fainted from an immunization or blood draw?	☐	☐
5. Have you received any immunizations in the last 4 weeks?	☐	☐
6. Are you pregnant or planning pregnancy soon? When was your last menstrual period	☐	☐
7. Are you breastfeeding?	☐	☐
8. Have you ever had cancer, leukemia, HIV, or any other immune system problem?	☐	☐
9. Have you ever been treated with chemotherapy or radiation treatment? If so, when	☐	☐
10. Have you ever been treated with medications that weaken the immune system? If so, when	☐	☐
11. Have you ever had a thymoma/thymectomy/splenectomy?	☐	☐
12. Have you ever had Guillain-Barré syndrome?	☐	☐

Please list all your medical conditions	Please list all the medications that you are currently taking including over the counter medicines: