



New Hanover County
International Travel Clinic

PATIENT LABEL

PATIENT QUESTIONNAIRE

ITINERARY

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

Country		City	
Country		City	
Country		City	
Leaving the United States on this Date: _____			Returning to the United States on this Date: _____
Will the trip be (check all that apply) <input type="checkbox"/> Urban <input type="checkbox"/> Rural <input type="checkbox"/> Both			ACCOMMODATIONS: (check any that apply) <input type="checkbox"/> Hotel <input type="checkbox"/> Camp/Tent <input type="checkbox"/> Dormitory <input type="checkbox"/> Private Residence/home <input type="checkbox"/> Ship

ALLERGIES/ MEDICAL CONDITIONS

1. Do you have any Medicine allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes Please List:	
2. Are you pregnant or contemplating pregnancy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
3. Are you breastfeeding?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
4. Have you had any severe reactions to past vaccines?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes Please List:	
5. List all medications you are currently taking, either prescription or over-the-counter (attach list if needed):	
6. Do you have any medical conditions, such as diabetes, heart disease, or lung disease? Please explain below:	

IMMUNIZATION RECORD

*Please note below any diseases you have had with dates or vaccinations with their dates.
PLEASE BRING YOUR IMMUNIZATION RECORD WITH YOU TO YOUR APPOINTMENT*

Immunization History	Date	Date	Date	Have you had this disease & if so, please state year	Unknown
Hep A (2 doses)					
Hep B (3 doses)					
Hep A/B (3 doses)					
Influenza					
MMR					
Meningococcal					
Pneumococcal Polysaccharide					
Polio Booster					
Rabies					
Td/Tdap					
Typhoid					
Varicella					
Yellow Fever					
Japanese Encephalitis					



PATIENT LABEL

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES, NO OR UNKNOWN	
1. Do you have sensitivity to sodium chloride or sorbitol?	<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

Date

RETURN COMPLETED FORM ONE (1) WEEK PRIOR TO SCHEDULED APPOINTMENT BY:
Faxing to: (910) 772-7805
Or
Mailing/Hand Delivering to: New Hanover County Health Department
2029 South 17th Street
Wilmington, NC 28401