MSFM TRAVEL INFORMATION FORM

MSFM Fax: 455-7125

Appointment date: _____

Provider:_____

**** This form MUST be filled out and returned at least 72 hours before your scheduled appointment****

Name:_____ Sex: _____ DOB:_____

Purpose of Trip: Business____ Pleasure____

Itinerary: Departure Date_____ Return Date _____

List in order of travel (Be as specific as possible)

Country	City	Dates of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Problems: Current_____ Past_____

History of Seizures? YES _____ NO _____

Adverse Reaction to Malaria Medication? YES_____ NO _____ N/A _____

Any Stomach Surgery, Antacids, or other Stomach Medication? YES_____ NO_____

WOMEN: Are you pregnant or planning to get pregnant in the near future? YES_____ NO_____

Last normal menstrual period _____ Birth Control Method _____

Current Medications:_____

Allergies:

Aspirin YES_____ NO_____

Eggs YES_____ NO_____

Sulfa YES_____ NO_____

Any reactions to previous immunizations? YES_____ NO _____

Immunization History: Give date of inoculation, if known.

	None	Unsure	Date
Tetanus, Td, DPT	☐	☐	_____
Polio, injection	☐	☐	_____
Polio, oral	☐	☐	_____
Measles, Mumps, Rubella	☐	☐	_____
Gamma Globin	☐	☐	_____
Cholera	☐	☐	_____
Hepatitis A	☐	☐	_____
Hepatitis B	☐	☐	_____
Meningococcal	☐	☐	_____
Typhoid	☐	☐	_____
Yellow Fever	☐	☐	_____
Other (Rabies, Plague,Japanese Encephalitis, Flu Vaccine, Pneumovax)	☐	☐	_____

Last TB Skin Test: Positive_____ Negative _____ Date: _____

You are expected to remain in the clinic 30 minutes after receiving immunizations.