

Patient information (please print)

Legal Name of Traveler: (First) _____ (Middle) _____ (Last) _____	DOB: _____ / _____ / _____ Month Day Year	Gender (circle): M F
		Place of Birth: _____
		City State Country

Address:	Street: _____
	City: _____ State: _____ Zip: _____

Patient's Phone Number: _____

Primary Health Care Provider:	Name: _____
	Phone: _____

Emergency Contact:	Name: _____ Relationship: _____
	Phone: _____

Itinerary

Date of Departure:	_____ / _____ / _____ Month Day Year	Duration: _____ days weeks months (check one)
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Return Date:	_____ / _____ / _____ Month Day Year
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Purpose of Travel (check all that apply):

Vacation Field Work Business Medical	Teaching Study Safari Adoption	Missionary Work Diving Climbing (specify elevation) _____	Spelunking/ Caving Relocation Other (specify): _____
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Type of Travel (check all that apply): **Accommodations (check all that apply):**

Group Tour Flexible Itinerary Independent	Cruise Fixed Itinerary Other (specify): _____	Compound Hotel Resort Camping	Private Home Cruise Ship Offshore Rig Hostel
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Destinations (include stopovers, list in order of travel):

Country	City	Duration (dates)	Urban	Rural

Notice of advance payment required.
 This notice is to inform you that most health plans do not offer coverage for immunizations for the purpose of travel. Therefore, UT Health Services will not file a claim for this visit with your health plan. Payment in full is expected at the time of your visit. Further, these services are not subject to any existing discount policies. You may choose to file a claim directly with your health plan.

I verify that the above information is complete and correct to the best of my knowledge.
 Signature: _____ Date: _____

Immunization history (Check had disease if applicable or list date of appropriate vaccination)

	Had disease	Vaccine #1 date	Vaccine #2 date	Vaccine #3 date	Not known		Had disease	Vaccine #1 date	Vaccine #2 date	Vaccine #3 date	Not known
Chickenpox/Varicella						Rubella					
COVID-19						Meningitis					
Cholera						Polio					
Hepatitis A						Pneumococcal					
Hepatitis B						Influenza					
Rabies						Tetanus/Diphtheria					
Japanese encephalitis						Typhoid injection					
Measles						Typhoid oral					
Mumps						Yellow fever					

1. Do you have an "International Certificate of Vaccination or Prophylaxis" (ICVP or Yellow Book): ____ YES ____ NO
2. Have you ever fainted or had an adverse reaction to any injections? ____ YES ____ NO
3. Do you have cancer, leukemia, AIDs, or other immune system problems? ____ YES ____ NO
4. Do you take cortisone, prednisone, other steroids, anti-cancer drugs or have, radiation therapy, or any oral/injectable immunobiologic agents? ____ YES ____ NO
5. Have you received a blood transfusion, blood products or immune globulin in the past year? ____ YES ____ NO
6. Do you have history of anaphylactic reaction from insect bites? ____ YES ____ NO
7. Any vaccines in the past 4 weeks? If yes, please state which vaccine(s). _____

Health History (List date if applicable):

Any allergies to medications: _____ Medical

Conditions: _____

Surgical History: _____ Recent hospitalization or illness (last 3 months): _____

History of any of the following (select all that apply):

- | | | | |
|-------------------|-----------------------|-------------------------|----------------------------|
| Nightmares | Seizure/epilepsy | Depression | Cardiac Problems/Pacemaker |
| Psoriasis | Psychiatric Disorders | Stomach/Colon Problems | Lung Disease |
| Altitude Sickness | Immune Disorder | Muscle or Bone Problems | |

Women:

1. Last Menstrual Period: ____/____/____
2. Are you currently pregnant? ____ YES ____ NO
3. Are you planning a pregnancy in the next 3 months? ____ YES ____ NO
4. Any contraception? ____ YES ____ NO
5. Are you nursing? ____ YES ____ NO

Health History (List date if applicable):

Prescription:

1. _____
2. _____
3. _____
4. _____
5. _____

Non-Prescription/Over the Counter:

1. _____
2. _____
3. _____
4. _____
5. _____

I verify that the above information is complete and correct to the best of my knowledge.

Signature: _____ Date: _____