Duke International Travel Clinic
Duke University Health System

Name:___________________________

MRN: ___________________________

Date: ________/________/200__________

All Patients Please Complete

A: ITINERARY (by Country):

Destination 1		Arrival Date		Departure Date	
Destination 2		Arrival Date		Departure Date	
Destination 3		Arrival Date		Departure Date	
Destination 4		Arrival Date		Departure Date	
Destination 5		Arrival Date		Departure Date	
Destination 6		Arrival Date		Departure Date	

***If more than 6 destinations, please use the back of this record to indicate this additional information.**

B: MEDICAL HISTORY

IMMUNIZATION RECORD – please record dates received if known and number of doses

Hepatitis A		MMR		PPD (TB)		Influenza	
Hepatitis B		Polio		Typhoid		Lyme	
Twinrix (Hep A/B)		Yellow Fever		Rabies		Td	
Pneumonia		Menactra		Menomune		Tdap	
Zostavax		Varicella		HPV		JEVAX	

ALLERGIES-Environmental and Medication (Yes or No):

Neomycin		Polymyxin B		Streptomycin	
Eggs		Peanut		Insect Bites/Stings	
Other Drug Allergies:					

Current Medications/Dietary Supplements ____

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Surgeries ____

Last Menstrual Period (mo/year)		Cardiac Problem (Y/N)	
Pregnant/Breast Feeding (Y/N)		Immunosuppressed (Y/N)	
Emotional/Neurologic problem (Y/N)		Spleen Removed (Y/N)	
Kidney Problem (Y/N)		Taking Blood Thinners (Y/N)	
Respiratory/Asthma Problem (Y/N)		Thymus dysfunction (Y/N)	
Recent use of oral or injectable steroid		Blood Products last 90 days	

C: PLEASE READ AND SIGN:

I understand that some vaccines can cause serious or deadly illness when administered to someone infected with HIV, immunosuppressed or pregnant (Signature) ________________________________ (Date) __________

I have received written immunization information, all questions have been answered to my satisfaction and I give my consent to receive these immunizations (signature) ________________________________ (Date) __________