IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

CONFIDENTIAL MEDICAL HISTORY FORM

NAME:_____**BIRTHDATE:**_____

⇨ REASON(S) FOR YOUR VISIT TODAY

☐ I am planning **International Travel**

Countries: _____

_____

_____

☐ Blood test (which?) _____

☐ TB (tuberculosis) test

☐ Vaccination for ☐ Immigration ☐ Work ☐ School ☐ Personal Health

Vaccine(s):_____

☐ Follow-up visit for: _____

☐ Exposed to a contagious disease.

Name of disease: _____

⇨ YOUR ALLERGIES

Are you allergic to any of these?

☐Latex ☐Eggs ☐Nuts
☐Chicken ☐Fish ☐Shellfish
☐Streptomycin ☐Neomycin ☐Bee stings
☐Sulfa drugs ☐Thimerosal

Any **other allergies** you have? ☐ **None**

To Drugs or Vaccines:

_____

To Foods or Environment:

_____

⇨ YOUR MEDICAL CONDITIONS

Have you ***ever*** had ...

seizures or **epilepsy**? ..... ☐ No ☐ Yes
trouble with you **thymus**? (not thyroid) ☐ No ☐ Yes
trouble with your **spleen**? ..... ☐ No ☐ Yes
treatment for **cancer**? ..... ☐ No ☐ Yes
depression or anxiety? ..... ☐ No ☐ Yes
another **psychological** condition? ..... ☐ No ☐ Yes
liver or **kidney** disease? ..... ☐ No ☐ Yes
heart or **lung** disease? ..... ☐ No ☐ Yes
Do you have weakened immunity or HIV? ☐ No ☐ Yes
Smoked **cigarettes** in the past 10 years? .. ☐ No ☐ Yes
Any **other medical conditions** you have
or are being treated for now? ..... ☐ No ☐ Yes

IF **YES** TO ANY OF THE ABOVE, PLEASE DESCRIBE:

⇨ MEDICINES YOU ARE TAKING NOW

List **all** antibiotics, steroids / prednisone, chemotherapy, and **all other prescription / non-prescription** drugs you take now.

_____

_____

_____

_____

⇨ FEMALES ONLY

Are you breastfeeding now? ☐ No ☐ Yes

When did your last menstrual period start? (Date) _____ ☐ I do not have menstrual periods

Contraception/Birth control method: ☐ None ☐ Birth Control Pill ☐ Condoms ☐ IUD ☐ Other _____

Are you pregnant now? ☐ No ☐ Yes ☐ Maybe

➔ If no, is there a reason why you could not possibly be pregnant now (for example "my uterus was removed" or "I don't have sex with men") _____

Are you planning to become pregnant soon? ☐ No ☐ Yes ➔ When? _____

CONFIDENTIAL MEDICAL HISTORY FORM

⇨ IF PLANNING INTERNATIONAL TRAVEL, PLEASE ANSWER THE FOLLOWING AS COMPLETELY AS YOU CAN:

Departure Date: _____ **Return Date:** _____	**Purpose of Trip** (*check all that apply*):	**Activities** (*check all that apply*):	
	☐ Pleasure or Vacation ☐ Business (*type*)_____ ☐ Study abroad ☐ Moving or relocating to live abroad ☐ Visiting my homeland ☐ Volunteer/Missionary/Humanitarian ☐ Other _____	☐ Camping ☐ Hiking or trekking ☐ Bicycling or motorcycling ☐ Caving ☐ High altitude >8000 ft ☐ Work with animals ☐ Work at orphanage	☐ Cruise ship ☐ Visit jungle area ☐ Visit rural area or village ☐ Visit farm ☐ Other _____

Please List Each Destination on your Itinerary (place or site, city or town, region or country)	**How Long at the Destination**	**Type of Accommodations** (e.g. hotel, resort, hostel, tent, apt, home stay)
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	

⇨ HELP US UNDERSTAND YOUR HEPATITIS RISK

Have you been tested for Hepatitis B infection? ☐ No ☐ Yes ☐ Not sure

Have you been tested for Hepatitis C infection? ☐ No ☐ Yes ☐ Not sure

Have you donated blood recently? ☐ No ☐ Yes

The following questions will help us determine your risk of past infection with Hepatitis B or C.
Please check all that apply.

(1) ☐ I was born in Asia / Pacific Is / Mideast / Africa / E. Europe / Amazon area of S. America *(which?* _____*)*

(2) ☐ My parent was born in Asia / Pacific Is / Mideast / Africa / E. Europe / Amazon area of S. America *(which?* _____*)*

(3) ☐ I have lived, traveled for at least 6 months, or had sexual contact with the local population in Asia / Pacific Is / Mideast / Africa / E. Europe / Amazon area of S. America *(which?* _____*)*

(4) ☐ I am Native American or Alaskan Native

(5) ☐ I have had a sex partner with Hepatitis B or C **

(6) ☐ I have lived in the same household with someone who has Hepatitis B

(7) ☐ I received a blood transfusion in the USA (before 1992) or in another country (anytime) *

(8) ☐ I am a male who has had sex with other males

(9) ☐ I have exchanged money or drugs for sex

(10) ☐ I have had a sexually transmitted disease

(11) ☐ I have had unprotected sex with a non-monogamous partner

(12) ☐ I have injected street drugs *

(13) ☐ My tattoo, piercing, or acupuncture could have been done with unsterile (dirty) equipment **

(14) ☐ I have been exposed to human blood or body fluids at work **

(15) ☐ **None of the above statements (1-14) apply to me**

(16) ☐ One or more of the above statements (1-14) apply to me — but I prefer not to say which one(s)

* MAJOR RISK FACTOR FOR HEPATITIS C ** MINOR RISK FACTOR FOR HEPATITIS C

CONFIDENTIAL MEDICAL HISTORY FORM

⇨ TELL US HOW YOU REACT TO VACCINES

What meal(s) have you eaten so far today? ☐ Breakfast ☐ Lunch ☐ Snack ☐ Nothing

Have you ***ever*** ... fainted or felt light-headed from a shot? ☐ No ☐ Yes

fainted or felt light-headed from having blood taken? ☐ No ☐ Yes

had any unusual reaction to a vaccine? ☐ No ☐ Yes

Describe: _____

⇨ TELL US ABOUT YOUR PAST VACCINATIONS

Please complete this grid as best you can.

If needed, please get assistance from your physician or parent before your AITC appointment.

	HAD THE VACCINE?	HOW MANY SHOTS?	EVER HAVE THE DISEASE?
Hepatitis A	☐ No ☐ Yes		☐ No ☐ Yes
Hepatitis B	☐ No ☐ Yes		☐ No ☐ Yes
MMR (Measles, Mumps, Rubella)	☐ No ☐ Yes		☐ No ☐ Yes - Measles ☐ No ☐ Yes - Mumps ☐ No ☐ Yes - Rubella ("German Measles")
Varicella ("Chickenpox")	☐ No ☐ Yes		☐ No ☐ Yes
	HAD THE VACCINE?	**YEAR of LAST DOSE**	**VACCINE TYPE**
Tetanus Booster (as adult)	☐ No ☐ Yes		☐ Td (Tetanus + Diphtheria only) ☐ Tdap (Tetanus + Diphtheria + Pertussis)
Typhoid	☐ No ☐ Yes		☐ Oral typhoid vaccine (pills) ☐ Typhoid vaccine injection (shot)
Polio Booster (as adult)	☐ No ☐ Yes		
Yellow Fever	☐ No ☐ Yes		

Please answer the following questions to help us assess your past vaccinations.

Did you have all your childhood vaccinations? ☐ No ☐ Yes ☐ Not sure

Did you attend college or university in the USA? ☐ No ☐ Yes ➔ during what years? _____

Where were you born? ☐ USA ☐ Other Country ➔ _____

If you were born outside the USA:

- At what age did you arrive in the USA? _____
- Did you get vaccines for immigration? ☐ No ☐ Yes ☐ Not sure

⇨ PLEASE SIGN HERE

I certify that the above information is correct to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions that I may have made in completing this form.

_____ _____

SIGNATURE OF CLIENT (OR PARENT/GUARDIAN) TODAY'S DATE

_____

PRINT NAME OF CLIENT (OR PARENT/GUARDIAN)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

NAME:_____**BIRTHDATE:**_____

Please leave these sections BLANK—AITC Staff will complete

HISTORICAL				TODAY'S VISIT							
# doses	Date of Last				Dis	Rec	Dec	Def	Ser #	Site	Lot #
		☐+Dz | Serol ☐+ ☐-	Hep A		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep B		☐	☐	☐	☐			
			Twinrix		☐	☐	☐	☐			
		☐Gardsl ☐Cervarx	HPV	☐Gardsl ☐Cervarx	☐	☐	☐	☐			
			Influenza	☐Inj ☐Pfree ☐FluMist	☐	☐	☐	☐			
		☐JE Vax ☐Ixiaro	JE	☐JE Vax ☐Ixiaro	☐	☐	☐	☐			
		☐ Menomu ☐ Menact ☐ Menveo	Meningococc	☐ Menomu ☐ Menact ☐ Menveo	☐	☐	☐	☐			
			MMR		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Measles		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Mumps		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Rubella		☐	☐	☐	☐			
			Pneumovax		☐	☐	☐	☐			
			PPD		☐	☐	☐	☐			
			Polio		☐	☐	☐	☐			
			Rabies	☐Imovax ☐Rabavert	☐	☐	☐	☐			
		☐Td ☐Tdap	Tetanus	☐Adacl ☐Td ☐Boostx	☐	☐	☐	☐			
		☐injectable ☐ oral	Typhoid	☐Typhim ☐Vivovif	☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Varicella		☐	☐	☐	☐			
			Yellow Fever		☐	☐	☐	☐			
			Zostavax		☐	☐	☐	☐			

Hep RISK ASSESSMENT	
Prior Risk Factor(s)	☐HBV ☐HCV ☐Neither ☐Unsure
Prior Testing	☐HBV ☐HCV ☐Neither ☐Unsure
HBV Test Result (if done)	☐Infected ☐Immune ☐Susceptible ☐Unsure
HBV Vax Series Completed ***Before*** Risk Began?	☐No ☐Yes ☐Unsure ☐N/A
HBV Panel Recommended?	☐No ☐Yes
HCV Ab Test Recommended?	☐No ☐Yes

RX	Dis	Rec	Dec	Def	Ordered
Malaria Prophylaxis	☐	☐	☐	☐	☐Malarone ☐Doxycycline ☐Chloroq ☐ Mefloquine
Travelers' Diarrhea	☐	☐	☐	☐	☐Cipro ☐Azithro ☐Rifaximin ☐Tinidazole
Altitude	☐	☐	☐	☐	☐Acetazolamide
Anaphylaxis	☐	☐	☐	☐	☐Epi-Pen
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

BLOOD TESTS	Dis	Rec	Dec	Def	Ordered
Measles IgG	☐	☐	☐	☐	☐
Mumps IgG	☐	☐	☐	☐	☐
Rubella IgG	☐	☐	☐	☐	☐
VZV IgG	☐	☐	☐	☐	☐
HAV Antibody	☐	☐	☐	☐	☐
HBs Antibody	☐	☐	☐	☐	☐
HBs Antigen	☐	☐	☐	☐	☐
HBc Antibody	☐	☐	☐	☐	☐
HCV Antibody	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

COUNSELING	
Food/Water Precautions	☐
Travelers' Diarrhea Management	☐
Insect/Mosquito Precautions	☐
Altitude Precautions	☐
Animal Bite/Rabies Precautions	☐

Additional Comments:

AITC Provider Signature: | Date: