### REASON(s) FOR YOUR VISIT TODAY
- [ ] Exposed to a contagious disease. Which? ____________________
- [ ] Planning International Travel
- [ ] Blood test. Which? ____________________
- [ ] TB test (tuberculosis)
- [ ] Vaccination (Reason) ____________________
  - [ ] Other. State reason ____________________

### YOUR ALLERGIES
- [ ] No Allergies
  - I am allergic to:
    - [ ] Latex
    - [ ] Thimerosal
    - [ ] Fish
    - [ ] Eggs
    - [ ] Neomycin
    - [ ] Sulfa drugs
    - [ ] Shellfish
    - [ ] Chicken
    - [ ] Streptomycin
    - [ ] Penicillin
    - [ ] Bee stings
    - [ ] Nuts

### MEDICINES YOU ARE TAKING NOW
List all prescription and non-prescription drugs you take regularly or occasionally.

### YOUR MEDICAL CONDITIONS
- Have you ever had ...
  - [ ] weakened immunity or HIV? ……………...  [ ] No  [ ] Yes
  - [ ] treatment for cancer? ………………...  [ ] No  [ ] Yes
  - [ ] seizures or epilepsy? ………………....  [ ] No  [ ] Yes
  - [ ] trouble with your thymus (not thyroid)…  [ ] No  [ ] Yes
  - [ ] trouble with your spleen? ……………….  [ ] No  [ ] Yes
  - [ ] liver or kidney disease? ……………....  [ ] No  [ ] Yes
  - [ ] heart or lung disease? ………………..  [ ] No  [ ] Yes
  - [ ] depression or anxiety? …………..…....  [ ] No  [ ] Yes
  - [ ] another psychological condition? …....  [ ] 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:
________________________________________

### TELL US ABOUT 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

### FEMALES ONLY
- Are you pregnant now?  [ ] No  [ ] Yes  [ ] Maybe
- Are you breastfeeding now?  [ ] No  [ ] Yes
- Contraception/Birth control method(s):  [ ] Birth Control Pill  [ ] Condoms  [ ] IUD  [ ] Implant  [ ] NuvaRing  [ ] Rhythm  [ ] NONE
  - If NONE, please check all that apply:  [ ] Not sexually active  [ ] No sex with men  [ ] Partner vasectomy  [ ] Tubal Ligation  [ ] Hysterectomy  [ ] Other ____________________
  
- Are you planning to become pregnant soon?  [ ] No  [ ] Yes  ➔ When? ____________________
- When did your last menstrual period start?  (Date) ____________________  [ ] I do not have menstrual periods

### HAVE YOU EVER ...
- Fainted or felt light-headed after a shot?  [ ] No  [ ] Yes
  - [ ] Or after a blood test or other needle?  [ ] No  [ ] Yes

Had any unusual reaction to a vaccine?  [ ] No  [ ] Yes

If YES to any of the above, please describe:
________________________________________
### Help Us Understand Your Viral Hepatitis Risk

Have you had a blood test for Hepatitis B or Hepatitis C infection?  

- No  
- Yes  
- Not sure  

Result: _______________________

Have you ever been told you could not donate blood?  

- No  
- Yes  

Have you donated blood in the last 5 years?  

- No  
- Yes

#### To help determine your risk of past infection with Hepatitis B or C: Please check all that apply.

These first 3 questions refer to Asia, Pacific Islands, Middle East, Africa, Eastern Europe, or the Amazon area of South America:

- I was born there  
- One or both of my parents was born there  
- I spent at least 6 months in __________________________________, or had sexual contact with local people there

- I received a blood transfusion in the USA (before 1992) or in another country (anytime)  
- My tattoo, piercing, or acupuncture could have been done with unsterile (dirty) equipment  
- I had contact with human blood or body fluids at work  
- I had a sex partner who had Hepatitis B or C  
- I exchanged money or drugs for sex  
- I had unprotected sex with a non-monogamous partner  
- I was born during 1945—1965  
- I am Native American or Alaskan Native  

- One or more of the above statements apply to me — but I prefer not to say which one(s)  
- None of the above statements apply to me

### If Planning International Travel, Please Answer the Following as Completely as You Can:

#### Departure Date:  
_________________________

#### Return Date:  
_________________________

#### Purpose of Trip (check all that apply):

- Pleasure or Vacation  
- Study abroad  
- Business (type)  
- Moving or relocating to live abroad  
- Visiting my homeland  
- Volunteer/Missionary/Humanitarian  
- Other _______________________

#### Activities (check all that apply):

- 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  
- SCUBA dive  
- Other _______________________

#### Please List Each Country You Will Visit

List in the order you will be visiting them  
Include all stopovers

<table>
<thead>
<tr>
<th>Country</th>
<th>How Long in the Country</th>
<th>Type of Accommodations</th>
</tr>
</thead>
<tbody>
<tr>
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#### How Long in the Country

- days  
- wks

#### Type of Accommodations

- (e.g. hotel, resort, hostel, tent, apt, home stay)
- Work at orphanage  
- Cruise ship  
- Visit jungle area  
- Visit rural area or village  
- Visit farm  
- SCUBA dive  
- Other _______________________

### 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)
### Historical

<table>
<thead>
<tr>
<th># Doses</th>
<th>Date of Last</th>
<th>Dis</th>
<th>Rec</th>
<th>Dec</th>
<th>Def</th>
<th>Ser #</th>
<th>Site</th>
<th>Lot #</th>
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</table>

- Cholera
- Hep A
- Hep B
- Twinrix
- Gardasil
- Gardasil
- HPV
- Influenza
- JE
- Ixiaro
- Menomu
- Menact
- Menveo
- MenACWY
- Bexsero
- Bexsero
- MenB
- MMR
- Measles
- Mumps
- Rubella
- Pneumovax23
- Prevnar13
- PPD
- Polio
- Rabies
- Adacel
- Adacel
- Tdap
- Tdap
- Typhoid
- Typhim
- Vivif
- Variella
- Yellow Fever
- Zostavax

### Prior Risk Assessment

<table>
<thead>
<tr>
<th>Prior Risk Factor(s)</th>
<th>HBV</th>
<th>HCV</th>
<th>Neither</th>
<th>Unsure</th>
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<tr>
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<table>
<thead>
<tr>
<th>HBV Test Result (if done)</th>
<th>Infected</th>
<th>Immune</th>
<th>Susceptible</th>
<th>Unsure</th>
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<table>
<thead>
<tr>
<th>HBV Vax Series Completed Before Risk Began?</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
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<table>
<thead>
<tr>
<th>HBV Panel Recommended?</th>
<th>No</th>
<th>Yes</th>
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<table>
<thead>
<tr>
<th>HCV Ab Test Recommended?</th>
<th>No</th>
<th>Yes</th>
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### Rx

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<tr>
<th>Rx</th>
<th>Dis</th>
<th>Rec</th>
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<td>Malaria Prophylaxis</td>
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### Blood Tests

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<td>Mumps IgG</td>
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### Counseling

<table>
<thead>
<tr>
<th>Food/Water Precautions</th>
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<tbody>
<tr>
<td>Travelers' Diarrhea Management</td>
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<tr>
<td>Insect/Mosquito Precautions</td>
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<tr>
<td>Altitude Precautions</td>
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<tr>
<td>Animal Bite/Rabies Precautions</td>
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### Additional Comments:

AITC Provider Signature: ____________________________ Date: ____________

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Please leave these sections BLANK—AITC Staff will complete.