July 2017

aitc

CONFIDENTIAL MEDICAL HISTORY FORM *(page 1 of 2)*

NAME:_____
BIRTHDATE:_____

⇨ REASON(S) FOR YOUR VISIT TODAY

☐ Exposed to a **contagious disease**. Which? _____

☐ Planning **International Travel**

☐ **Blood test.** Which? _____

☐ **TB test** (tuberculosis)

☐ **Vaccination** (Reason)_____

(Which vaccine(s)? _____

☐ 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

PLEASE LIST ANY **OTHER** ALLERGIES:

⇨ 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:

⇨ 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:

_____

What meal(s) have you eaten so far today?

☐ Breakfast ☐ Lunch ☐ Snack ☐ Nothing

⇨ 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

CONFIDENTIAL MEDICAL HISTORY FORM *(page 2 of 2)*

⇨ 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.***

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

☐ 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 lived with someone who had Hepatitis B or C

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

☐ I had a sexually transmitted disease

☐ I injected street drugs

☐ 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:

_____

<u>Purpose of Trip</u> (*check all that apply):*

☐ Pleasure or Vacation ☐ Study abroad

☐ Business (*type*)_____

☐ Moving or relocating to live abroad

☐ Visiting my homeland

☐ Volunteer/Missionary/Humanitarian

☐ Other _____

<u>Activities</u> (*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	**How Long in the Country**	**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	

⇨ 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 #
			Cholera		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep A		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep B		☐	☐	☐	☐			
			Twinrix		☐	☐	☐	☐			
		☐Gardsl ☐Cervarx	HPV	☐Gardasil	☐	☐	☐	☐			
			Influenza	☐Inj ☐Pfree ☐FluMist	☐	☐	☐	☐			
		☐JE Vax ☐Ixiaro	JE	☐Ixiaro	☐	☐	☐	☐			
		☐ Menomu ☐ Menact ☐ Menveo	MenACWY	☐ Menactra ☐ Menveo	☐	☐	☐	☐			
		☐ Bexsero ☐Trumen	MenB	☐ Bexsero	☐	☐	☐	☐			
			MMR		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Measles		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Mumps		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Rubella		☐	☐	☐	☐			
			Pneumovax23		☐	☐	☐	☐			
			Prevnar13		☐	☐	☐	☐			
			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: