



**CONFIDENTIAL MEDICAL HISTORY
FORM (page 3 of 3)**

NAME: _____

BIRTHDATE: _____

******* STOP ! PLEASE LEAVE THE AREA BELOW BLANK—AITC Staff will complete *******

HISTORICAL				TODAY'S VISIT							
# doses	Date of Last			Dis	Rec	Dec	Def	Ser #	Site	Lot #	
			Cholera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Primary <input type="checkbox"/> Bivalent	COVID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Hep A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Hep B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Enderix <input type="checkbox"/> HepLISAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Twinrix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Hib	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Gardsl <input type="checkbox"/> Cervarx	HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Inj <input type="checkbox"/> PF <input type="checkbox"/> HD <input type="checkbox"/> FluMist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> JE Vax <input type="checkbox"/> Ixiaro	JE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Ixiaro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Jynneos	MPox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Jynneos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Menact <input type="checkbox"/> Menveo	MenACWY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Menactra <input type="checkbox"/> Menveo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Bexsero <input type="checkbox"/> Trumen	MenB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Bexsero	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			MMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Pneumovax23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Prev13	Prevnar20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Rabies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Imovax <input type="checkbox"/> Rabavert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Td <input type="checkbox"/> Tdap	Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Adacel <input type="checkbox"/> Td <input type="checkbox"/> Boostrx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> TicoVac	TBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> TicoVac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> injectable <input type="checkbox"/> oral	Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Typhim <input type="checkbox"/> Vivovif	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> +Dz Serol <input type="checkbox"/> + <input type="checkbox"/> -	Varicella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/> Stamaril <input type="checkbox"/> YF-Vax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	Shingrix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Hep RISK ASSESSMENT	
Prior Risk Factors	<input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> Neither <input type="checkbox"/> Unsure
Prior Testing	<input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> Neither <input type="checkbox"/> Unsure
HBV Test Result (if done)	<input type="checkbox"/> Infected <input type="checkbox"/> Immune <input type="checkbox"/> Susceptible <input type="checkbox"/> Unsure
HBV Series Complete Before Risk Began?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure <input type="checkbox"/> N/A
HBV Panel Recommended?	<input type="checkbox"/> No <input type="checkbox"/> Yes
HCV Ab Test Recommended?	<input type="checkbox"/> No <input type="checkbox"/> Yes

BLOOD TESTS	Dis	Rec	Dec	Def	Ordered
Measles IgG	<input type="checkbox"/>				
Mumps IgG	<input type="checkbox"/>				
Rubella IgG	<input type="checkbox"/>				
VZV IgG	<input type="checkbox"/>				
HAV Antibody	<input type="checkbox"/>				
HBs Antibody	<input type="checkbox"/>				
HBs Antigen	<input type="checkbox"/>				
HBc Antibody	<input type="checkbox"/>				
HCV Antibody	<input type="checkbox"/>				
	<input type="checkbox"/>				

RX	Dis	Rec	Dec	Def	Ordered
Malaria Prophylaxis	<input type="checkbox"/> MAL <input type="checkbox"/> Doxy <input type="checkbox"/> CQ <input type="checkbox"/> MQ <input type="checkbox"/> PQ <input type="checkbox"/> TQ				
Travelers' Diarrhea	<input type="checkbox"/> Cipro <input type="checkbox"/> Azithro <input type="checkbox"/> Rifaximin <input type="checkbox"/> Tinidazole				
Altitude	<input type="checkbox"/> Acetazolamide				
Anaphylaxis	<input type="checkbox"/> Epi-Pen				
Freq UTI	<input type="checkbox"/> Nitrofurantoin				
Jet Lag	<input type="checkbox"/> Ambien				
Motion Sickness	<input type="checkbox"/> Scopolamine Patch				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COUNSELING	
Food/Water Precautions	<input type="checkbox"/>
Travelers' Diarrhea Management	<input type="checkbox"/>
Insect/Mosquito Precautions	<input type="checkbox"/>
Altitude Precautions	<input type="checkbox"/>
Animal Bite/Rabies Precautions	<input type="checkbox"/>

Additional Comments:

AITC Clinician Signature: _____ Date: _____