

Baylor Travel Medicine

3701 Kirby, Suite 100, Houston, TX 7098

Phone: 713-798-7700, opt. 4

Fax: 713-798-2752

Please complete all 3 pages and fax to us at least 2 business days prior to your appointment.
Please clearly **PRINT** all information.

Referred by: _____

Clinic Appt. Date: _____ Time: _____

Personal Information

Full Name: _____ AKA: _____

DOB: _____ Age: _____ yrs SEX: M F

Home Phone: (____) _____ Cell Phone: (____) _____

Street: _____

City: _____ State: _____ Zip Code: _____

Preferred e-mail Address: _____

May we leave a message/info re: appt on Home answering machine Voicemail at work E-mail

Country of birth: _____

Employment Information (If traveler is a minor or student, give parent/guardian information.)

Occupation: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (____) _____ Ext: _____

Contact Person's Name and Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____

Preferred daytime numbers: _____

Primary Care Physician _____ Phone _____

Travel Information

Itinerary: Departure Date: _____ Return Date: _____ Total Length of trip: _____ days

Purpose of Travel (Circle all that apply)

Business Meeting
Field Work
Relocation
Teaching/Study
Missionary Work
Other _____

Vacation
Diving
Safari
Climbing
Visiting Friends and
Relatives

Type of Travel (Circle all that apply)

Group / Tour
Independent
Fixed Itinerary
Flexible Itinerary
Cruise
Other _____

Accommodations

Compound
Camp/Tent
Hotel/Resort
Private/Rented home
Cruise Ship
Off-shore Rig
Other _____

Destination (s), including airport stopovers, in order of travel: (add additional pages, if necessary)

Country	City	Arrival Date	Departure Date	Duration	Urban	Rural

Traveler Name: _____

Immunization History:

Please obtain all available immunization records prior to your appointment.

Fax a copy and bring the originals to your appointment.

If you have a yellow Certificate of Immunization, bring it to your appointment.

Check "had disease" if applies, or list date of vaccine in the appropriate box	Had Disease	Vaccine #1 date	Vaccine #2 date	Vaccine #3 date	Not Known		Had Disease	Vaccine date	Not Known
Chickenpox (Varicella)						Meningococcal Meningitis			
Hepatitis A						Polio			
Hepatitis B						Pneumococcal Pneumonia			
Rabies						Influenza			
Japanese Encephalitis						Tetanus/Diphtheria (Td)			
Measles (Rubeola, 7-day measles)						Typhoid, Injection			
Mumps						Typhoid, oral			
Rubella (German or 3-day measles)						Yellow Fever			

Weight: _____

- | | YES | NO |
|------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you have cancer, leukemia, HIV/AIDS/any other immune system disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently receiving chemotherapy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently receiving radiation therapy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had your thymus gland removed (or tumor of), DiGeorge Syndrome?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have myasthenia gravis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have/or have you had Guillain Barre syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you take cortisone/prednisone/other steroids (excluding nasal sprays)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you live/work closely with anyone who has cancer/HIV/AIDS or with infants?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you received blood, blood products or platelets in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any reaction to a vaccine given in this clinic?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a convulsion/seizure/brain infection/neurologic problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a medical condition that is stable now, but that may recur during travel?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any GI problems (reflux/ulcer/IBS/Crohn's/diarrhea/constipation)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you experience strange dreams/nightmares?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have insomnia?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have G6PD deficiency?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have psoriasis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any eye conditions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are you prone to motion sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have a low platelet count/coagulation disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever fainted from having an injection/blood drawn? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a serious adverse effect from any vaccination?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had generalized hives/itching from medications or insect bites? | <input type="checkbox"/> | <input type="checkbox"/> |

Women:

24. Are you pregnant, planning to become pregnant within 3 months, or nursing?

Please explain "yes" answers:

Traveler Name: _____

Surgical history:

Medical Problems:

Allergies: **Check all that apply:**

Drug/Food	Rash/hives	Shock	Respiratory Difficulty	Nausea/diarrhea	Approx date	Medical care Needed?

Current **prescription** medications:

Medication	Dose	Reason

Current **non-prescription** medications:

Medication	Dose	Reason

Additional comments:

Signature

Date

Thank you, the Baylor Travel Medicine fax number is 713-798-2752