University of Louisville Vaccine and International Travel Center

Legal Name:_____ **Age:**_____ **Weight:**_____ **DOB:**_____
Last First M.I mm/dd/year

Preferred Name_____ **Height:**_____ **Gender at Birth:** ☐ **Male** ☐ **Female**

We recognize the importance of gender specific information regarding your care.
Do you think of yourself as: ☐ **Male** ☐ **Female** ☐ **Trans Male to Female** ☐ **Trans Female to Male** ☐ **Other** _____

Home Address_____ _____ _____ _____
Street Address City State Zip

Phone:_____ _____ **Email:**_____
Home or Cell Work

Employer:_____ **Occupation:**_____

Emergency Contact:_____ _____ _____
(required) Name Relationship Phone Number

Pharmacy and Primary Care Provider Information

Pharmacy Name:	**Pharmacy Phone:**
Pharmacy Address:	
Primary Care Provider (PCP):	**Primary Care Phone:**

Travel Information

Please list the countries you are traveling to, in the order you will visit them:

Date of Departure	Destination (City, Country)	Date of Return or Transfer	Length of Stay

Please mark all that apply to your travel plans:

Purpose:		**Accommodations:**		**Activities:**	
☐ Leisure	☐ Business	☐ Resort	☐ Hotel	☐ Sightseeing	☐ Climb/Hike
☐ Missions	☐ Visit Family/Friends	☐ Cruise Ship	☐ Rural Travel	☐ Camping	☐ Safari
☐ Study Abroad	☐ Adoption	☐ Staying with Family/Friends		☐ Business Meetings	

Immunization History:

1) Have you had two (2) measles, mumps, and rubella (MMR) vaccine? ☐ **Yes** ☐ **No** ☐ **Unknown**

2) What was the date of your last *tetanus/diphtheria (Td/Tdap)* injection? _____

3) Have you had *chickenpox*, or received two (2) doses of the varicella vaccine? ☐ **Yes** ☐ **No** ☐ **Unknown**

4) When was your last TB skin test? _____

5) Have you ever had a reaction to a vaccine that required medical treatment (a doctor's office visit or emergency care)?
If yes, please explain the specific type of reaction:

_____

6) Please list any vaccines you have received in the past 30 days:

Do you have heart problems?	☐ Yes	☐ No	**Are you allergic to bee stings?**	☐ Yes	☐ No
Do you have high blood pressure or take high blood pressure medicine?	☐ Yes	☐ No	**Do you have diabetes? If yes, do you take insulin? ☐ Yes ☐ No**	☐ Yes	☐ No
Do you have bleeding problems, take anticoagulants, aspirin, or aspirin therapy?	☐ Yes	☐ No	**Do you have tuberculosis, or tested positive for tuberculosis?**	☐ Yes	☐ No
Do you have lung problems, asthma, or chronic bronchitis/shortness of breath?	☐ Yes	☐ No	**Do you have a history of depression, anxiety, or other psychiatric disorder?**	☐ Yes	☐ No
Are you currently taking antibiotics?	☐ Yes	☐ No	**Have you ever had a seizure, convulsion, epilepsy, neurological condition, or brain infection?**	☐ Yes	☐ No
Are you currently experiencing any respiratory infections or other acute illness or infections?	☐ Yes	☐ No	**Do you have a history of Guillian-Barre Syndrome?**	☐ Yes	☐ No
Do you have any skin conditions (e.g., psoriasis)?	☐ Yes	☐ No	**Are you prone to motion sickness?**	☐ Yes	☐ No
Do you experience nightmares or insomnia?	☐ Yes	☐ No	**Are you allergic to eggs, yeast, or any other foods?**	☐ Yes	☐ No
Do you have any immune system problems, such as cancer, HIV, or AIDS?	☐ Yes	☐ No	**Do you take any cortisone, prednisone, steroids, chemotherapy, or other biologic (e.g., Humira, Remicade, etc.)?**	☐ Yes	☐ No
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge Syndrome, or thymoma?	☐ Yes	☐ No	**Do you have any eye conditions (e.g., glaucoma)?**	☐ Yes	☐ No
Do you have stomach/bowel conditions, such as frequent diarrhea, constipation, or irritable bowel syndrome?	☐ Yes	☐ No	**Have you ever fainted from an injection or from having your blood drawn?**	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No	**During the past three (3) months, have you received a transfusion of blood or plasma, or been given immune globulin?**	☐ Yes	☐ No
Do you drink?	☐ Yes	☐ No	**Do you have ANY other health issues for which you see a health professional? Please describe:** _____ _____		

Do you have any medication or food allergies?

Medication: ☐ **Yes** ☐ **No**

Food: ☐ **Yes** ☐ **No**

If yes, to what are you allergic? _____

Do you think of yourself as:

☐ **Straight or heterosexual** ☐ **Lesbian, gay or homosexual**
☐ **Bisexual** ☐ **Something else** ☐ **Don't know**

Are you interested in receiving information about reducing your risk of HIV transmission? ☐ **Yes** ☐ **No**

Are you currently taking any medications (including oral contraceptive)?

☐ **Yes** ☐ **No**

If yes, please list all medications you are currently taking or will be taking during your trip:

_____

_____

Questions for Women:

Do you use a contraceptive or birth control (e.g., condoms, pills, surgical sterility)?	☐ **Yes**	☐ **No**
Are you pregnant?	☐ **Yes**	☐ **No**
Do you plan to become pregnant in the next three (3) months?	☐ **Yes**	☐ **No**
Are you currently breastfeeding (nursing)?	☐ **Yes**	☐ **No**

By signing, I am stating that the above information is true and accurate to the best of my knowledge. The UofL Vaccine and International Travel Center does not accept insurance for payment, and does no billing or filing with insurance. Payment is due at the time of service by cash, check, or credit card. I understand that insurance may not cover these services, and I cannot submit for reimbursement. I understand I will receive a Vaccine Information Statement (VIS) for all vaccines received at my appointment via email or hard copy. I accept the risks and benefits of all vaccines I will receive, and I am requesting they be provided to me. I understand declining recommended vaccines and medications may place me at risk for illness.

Traveler/Patient Signature _____ **Date**_____
(under 18 years of age must have parent/guardian signature)

Directions to:
University of Louisville
Global Health Center - Travel Clinic
501 East Broadway, suite 110
Louisville, KY 40202
502-852-6464

From Louisville I-64 West

3rd Street Exit
3rd Street to Broadway – Turn Left onto Broadway
Travel down Broadway 6 blocks to Jackson Street
Turn Left onto Jackson Street
MedCenter One is immediately on your right
Turn right into the alley behind the building
Park in the fenced lot in Spaces labeled "Visitors/Patient Parking"
or spaces # 30-34 and 57-61.

From Indiana I65 South

Jefferson Street Exit
Jefferson Street to 1st Street – Turn Left onto 1st Street
1st Street to Broadway – Turn Left onto Broadway
Travel three blocks — Turn Left onto Jackson Street
MedCenter One is immediately on your right
Turn right into the alley behind the building
Park in the fenced lot in Spaces labeled "Visitors/Patient Parking"
or spaces # 30-34 and 57-61.

From Louisville I-65 North

Broadway exit
At the end of the ramp, go turn Right onto Broadway
Go 5 blocks –Turn Left onto Jackson Street
MedCenter One is immediately on your right
Turn right into the alley behind the building
Park in the fenced lot in Spaces labeled "Visitors/Patient Parking"
or spaces # 30-34 and 57-61.

Note: You have several parking options.

Meters are located on the streets surrounding the building. If you want to park at a meter on Broadway, enter the front of the building and suite 110 is on your left inside the lobby. If you prefer to park in the Spaces labeled "Visitors/Patient Parking", park then walk to the front of the building on the Broadway side. Enter the front door and suite 110 is on your left inside the lobby.