

University of Louisville Vaccine and International Travel Center



Legal Name: _____ **Age:** _____ **Weight:** _____ **DOB:** _____
Last First Middle name 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: <input type="checkbox"/> Leisure <input type="checkbox"/> Business <input type="checkbox"/> Missions <input type="checkbox"/> Visit Family/Friends <input type="checkbox"/> Study Abroad <input type="checkbox"/> Adoption	Accommodations: <input type="checkbox"/> Resort <input type="checkbox"/> Hotel <input type="checkbox"/> Cruise Ship <input type="checkbox"/> Rural Travel <input type="checkbox"/> Staying with Family/Friends	Activities: <input type="checkbox"/> Sightseeing <input type="checkbox"/> Climb/Hike <input type="checkbox"/> Camping <input type="checkbox"/> Safari <input type="checkbox"/> Business Meetings
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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) Have you ever tested positive for Tuberculosis? _____
- 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you allergic to bee stings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have high blood pressure or take high blood pressure medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have diabetes? If yes, do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have bleeding problems, take anticoagulants, aspirin, or aspirin therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have tuberculosis, or tested positive for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have lung problems, asthma, or chronic bronchitis/shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a history of depression, anxiety, or other psychiatric disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently taking antibiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had a seizure, convulsion, epilepsy, neurological condition, or brain infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently experiencing any respiratory infections or other acute illness or infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a history of Guillian-Barre Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any skin conditions (e.g., psoriasis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you prone to motion sickness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience nightmares or insomnia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you allergic to eggs, yeast, or any other foods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any immune system problems, such as cancer, HIV, or AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you take any cortisone, prednisone, steroids, chemotherapy, or other biologic (e.g., Humira, Remicade, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge Syndrome, or thymoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any eye conditions (e.g., glaucoma)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have stomach/bowel conditions, such as frequent diarrhea, constipation, or irritable bowel syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever fainted from an injection or from having your blood drawn?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	During the past three (3) months, have you received a transfusion of blood or plasma, or been given immune globulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you think of yourself as:		
Food: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian, gay or homosexual		
If yes, to what are you allergic? _____			<input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know		
			Are you interested in receiving information about reducing your risk of HIV transmission? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you currently taking any medications (including oral contraceptive)?			Questions for Women:		
<input type="checkbox"/> Yes <input type="checkbox"/> No			Do you use a contraceptive or birth control (e.g., condoms, pills, surgical sterility)?		
If yes, please list all medications you are currently taking or will be taking during your trip: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____			Are you pregnant?		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Do you plan to become pregnant in the next three (3) months?		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Are you currently breastfeeding (nursing)?		
			<input type="checkbox"/> Yes <input type="checkbox"/> 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 not bill or file insurance. Payment is due at the time of service by cash, credit/debit card. I understand that insurance may not cover these services. 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**

Red brick building in the corner of
East Broadway and Jackson St.

Note: You have several parking options.

You can park for free at the parking lot behind the building, in the spaces labeled “2 Hours Visitors/Patient Parking” or pay the meters on the streets surrounding the building. You can enter the building through the front door, on East Broadway. We are located in suite 110, on your left.