



University of Louisville Vaccine and International Travel Center

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

Preferred Name _____ 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:
<input type="checkbox"/> Leisure	<input type="checkbox"/> Resort	<input type="checkbox"/> Sightseeing
<input type="checkbox"/> Missions	<input type="checkbox"/> Hotel	<input type="checkbox"/> Climb/Hike
<input type="checkbox"/> Study Abroad	<input type="checkbox"/> Cruise Ship	<input type="checkbox"/> Camping
<input type="checkbox"/> Business	<input type="checkbox"/> Rural Travel	<input type="checkbox"/> Business Meetings
<input type="checkbox"/> Visit Family/Friends	<input type="checkbox"/> Staying with Family/Friends	<input type="checkbox"/> Safari
<input type="checkbox"/> Adoption		

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?	<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?			Do you think of yourself as:		
Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian, gay or homosexual		
Food: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know		
If yes, to what are you allergic? _____			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 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 (5B)

Take 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.

From Indiana I-65 South – Kennedy Bridge

Jefferson Street Exit (136 C)

Take Jefferson Street to 1st Street – Turn Left onto 1st Street
Take 1st Street to Broadway – Turn Left onto Broadway
Travel three blocks — Turn Left onto Jackson Street
MedCenter One is immediately on your Right.

From Louisville I-65 North

Broadway Exit (136 A)

At the end of the ramp, Turn Right onto Broadway
Go 5 blocks – Turn Left onto Jackson Street
MedCenter One is immediately on your Right.

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 reserved visitor spots behind the building, 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.