Would you, please . . .

... fill in this form? Bring it with you when you come to the Travel Clinic. Thank you!

Identification

Name: Sex:

Date of birth:

Street address:

City, State ZIP code:

Telephone: ()

e-mail address:

Medical history

Medicines:

Are you taking . . .

Antacids or stomach medicine?	yes	no	not sure
Antibiotics?	yes	no	not sure
Anti-cancer drugs?	yes	no	not sure
Asthma or chest medicine?	yes	no	not sure
Birth control pills?	yes	no	not sure
Depression treatment medicine?	yes	no	not sure
Heart disease medicine?	yes	no	not sure
Hormone replacement for menopause?	yes	no	not sure
Iron?	yes	no	not sure
Steroids?	yes	no	not sure
Theophylline?	yes	no	not sure
Vitamins?	yes	no	not sure

Please list **all** the drugs you are taking **here**:

Allergies:

IMPORTANT! Please read this carefully, especially if you're not sure about an allergy: This question is only about allergies that you already know of.

Do you have any allergies that you *already know* that you have? yes no

If you don't have allergies that you already know of, please go on to the next question. If you do know that you have allergies, please circle them on the list below or write them in:

or write them in:

Egg allergy
Bread allergy
Insect sting allergy
Mouse protein allergy
Neomycin allergy
Neomycin allergy
Thimerosal allergy

Other drug allergy. What? Other allergy. What?

Have you had hives (sometimes called "urticaria")?

yes no not sure

Immunizations in the past:

Did you go to elementary school in the U.S.?

yes no not sure

Did you serve in the U.S. military or the Peace Corps?

yes no not sure

IMPORTANT! Call your mother, or your doctor, if necessary, to find out what immunizations you have received. <u>Please bring copies of immunization records</u>.

GO ON TO THE NEXT COLUMN, PLEASE

I nink about tetanus snots. Maybe you got your last snot	Did you ever have sningles or zoster?
when you had an injury. Maybe you got your first shots	yes no not sure
when you started school.	Did you ever get the shingles vaccine or zoster vaccine?
Did you get immunizations for DPT, Td, Tdap, DT, or	yes no not sure
tetanus? yes no not sure	If yes, when did you get the shingles vaccine or zoster
If yes, did you get your last shot within the past ten	vaccine? Year: not sure
years? yes no not sure	, accine.
If yes, did you get your last shot within the past five	Did you get the <i>Haemophilus influenzae</i> b conjugate vac-
years? yes no not sure	cine? yes no not sure
When did you get your last tetanus shot?	D'1
Year: not sure	Did you get meningococcal immunization after 1980?
	yes no not sure
Did you get immunizations for polio? yes no not sure	If yes, when was the last time? Year: not sure
If yes, did you get any as an adult?	
yes no not sure not an adult	Did you get influenza immunization? yes no not sure
If yes, did you get any in the past five years?	If yes, when was the last time? Year: not sure
yes no not sure	
·	Did you get pneumococcal immunization after 1977?
Did you get immunization for measles? These questions are	yes no not sure
about regular measles, hard measles, red measles, ten-day	,
measles, or sarampion—NOT about rubella, German	Did you get the Hepatitis B immunizations after 1980? Do
measles, or three-day measles. yes no not sure	not confuse this with Hepatitis A. The Hepatitis B immuni-
If yes, did you get immunized 1968 or later?	zation series is usually 3 shots given over 6 months. The
	•
yes no not sure	cost varies, but usually it is over \$100 for the 3 shots. Often
If yes, did you get at least 2 shots after your first birth-	health care workers get it. yes no not sure
day? yes no not sure	If yes, did you get the full series of 3 or 4 hepatitis B
Did you ever have measles? yes no not sure	shots? yes no not sure
Did you get immunization for mumps? yes no not sure	Did you get yellow fever immunization? yes no not sure
Did you ever get mumps? yes no not sure	If yes, when was your last shot? Year: not sure
	If yes, were you pregnant then? yes no not sure
Did you get immunization for rubella, German measles, or	
three-day measles? yes no not sure	Did you get typhoid immunization? yes no not sure
Did you ever have a blood test done that said that you	If yes, what kind did you get?
were immune to rubella, German measles, or three-day	pills shots both not sure
measles? yes no not sure	If you got shots, which kind did you get?
This box has a question for women. The rest of this	□very painful & needed at least 2
questionnaire is for everyone. Do you think you might	□not very painful & needed just 1
ever have a baby in the future? yes no not sure	□both
ever have a baby in the future: yes no not sure	□not sure
TT1 ' 1 - 14 1 ' 1 ' - 11	If you had shots or pills, when was your last immuniza-
Think about chickenpox or varicella.	
Did you ever have chickenpox or varicella yourself?	tion? Year: not sure
yes no not sure	If you had shots or pills, what kind was your last im-
Did you ever live in a household when someone else in	munization? pills shots not sure
the household got sick with chickenpox, varicella,	If your last one was shots, which kind did you get?
shingles, or zoster? yes no not sure	☐ very painful & needed at least 2
Did you get immunization for chickenpox or varicella	☐ not very painful & needed just 1
after 1990? yes no not sure	\square not sure
·	

GO ON TO THE NEXT COLUMN, PLEASE

Did you get rabies immunization? yes no not sure If yes, when was your last shot? Year: not sure If yes, did you have your blood drawn to check on the titer or level of rabies antibodies? yes no not sure If yes, when? Month/year: not sure

Did you get COVID-19 immunization? yes no not sure If yes, how many shots? yes no not sure

Did you get Japanese encephalitis immunization?

yes no not sure If yes, when was your last shot? Year: not sure

Have you ever had Hepatitis A? *This is NOT the same as Hepatitis B.* yes no not sure

Did you get immune globulin in the last 6 months? This is also called gamma globulin or immune serum globulin. Do not confuse with Hepatitis B. yes no not sure If yes, when was your last shot? Year: not sure

Did you get inactivated hepatitis A vaccine (Havrix, Vaqta, or Twinrix) after 1993? *Do not confuse with Engerix or hepatitis B vaccine.* yes no not sure

If yes, when was your last shot? Year: not sure If yes, did you get the full series of 2 hepatitis A shots at least 6 months apart? yes no not sure

We have a reason for asking each of the questions on this questionnaire. Your answers may affect the vaccines and drugs that you get. If you are curious why we include some of the questions, please ask us. We will be glad to explain.

Special activities:

What kind of work do you do?

Are you an airplane pilot? yes no not sure Are you a rock climber? yes no not sure

IMPORTANT! Please read this carefully: Think about other activities in which you participate. Are any of them similar to flying an airplane or rock climbing in that they require you to have fine coordination and spatial discrimination?

yes no not sure

If yes, please list the activities:

Do you work in a health care setting? yes no not sure If yes, do you sometimes touch moist surfaces of your patients, work with blood, or contact other body fluids? yes no not sure

If yes, do you sometimes work around newborns, cancer patients, patients taking steroids, AIDS patients, or other patients with weak immune systems?

yes no not sure

Illnesses:

Do you have a problem with your immune system?

Do you have leukemia? yes no not sure
Do you have lymphoma? yes no not sure
Do you have other cancer? yes no not sure
Have you had previous serious reactions to vaccines?

yes no not sure

If yes, please describe:

Have you received radiation therapy? yes no not sure

If yes, what was the reason for it?

If yes, when was the last time? Year: not sure

Have you received a blood transfusion or plasma?

yes no not sure If yes, what was the reason for it?

If yes, when was the last time? Year: not sure Do you have anemia? yes no not sure

Do you wear glasses or contact lenses? ves

Do you wear glasses or contact lenses? yes no not sure Do you have any other eye problems? yes no not sure

If yes, what kind of problems?

retinal disease

Other. Please list:

GO ON TO THE NEXT COLUMN, PLEASE

Has a doctor told you that you have high blood pressure or heart disease? yes no not sure

If yes, what is the diagnosis?

If yes, are you taking any medicines for it?

yes no not sure

If yes, be sure you list all of the medicines on page 1.

Has a doctor told you that you have asthma or other lung disease? yes no not sure

If yes, what is the diagnosis?

If yes, are you taking any medicines for it?

yes no not sure

If yes, be sure you list all of the medicines on page 1.

Do you have liver disease? yes no not sure

Do you have kidney disease? yes no not sure

Do you have migraine headaches or a tremor (a shakiness)? yes no not sure

Are you taking any medicines for these problems?

yes no not sure

If yes, be sure you list all of the medicines on page 1.

Do you have convulsions, seizures, epilepsy, or other nervous system problems? yes no not sure

Are you taking any medicines to prevent seizures?

ves no not sure

If yes, be sure you list all of the medicines on page 1.

Do you have depression? yes no not sure Do you have other mental illness or psychiatric problems?

yes no not sure

These questions are important because some antimalaria drugs can be dangerous if you have these problems.

Please list any other medical problems:

This box has questions for women. The rest of this questionnaire is for everyone:

Doctors usually avoid giving any drugs or vaccines to pregnant women unless there is a specific need. Are you pregnant? Do you think you might get pregnant within three months of getting a shot or taking drugs? Are you breastfeeding? If so, you should check with a doctor before getting drugs or vaccines.

Are you pregnant?

Are you breastfeeding?

Do you think you might get pregnant in the next three months?

yes no not sure yes no not sure

Family OR household health:

IMPORTANT! Please read this carefully: Please think about people who are alive now AND who NOW live with you in your household. Do any of them have:

• a problem with the immune system?	yes	no	not sure
• leukemia?	yes	no	not sure
• lymphoma?	yes	no	not sure
• other cancer?	yes	no	not sure
• a transplant	yes	no	not sure

Think about these people some more. Are any of them now:

- on radiation therapy?taking steroids?yes no not sureyes no not sure
- taking anti-cancer drugs? yes no not sure
- taking other drugs that suppress immunity?

yes no not sure

GO ON TO THE NEXT COLUMN, PLEASE

Travel plans

Please list all the countries you plan to visit. List them in the order you plan to visit them. For example: "USA to Brazil to Argentina to USA." Include all countries, even if you are just changing planes at an airport. If you have an itinerary or travel folder that lists your plans, look at it. Bring it with you to the clinic. WRITE YOUR LIST HERE:

USA to:

How long will you be gone?

When will you be leaving Omaha?

When will you be leaving the USA?

Activities: What do you expect to do? Circle as many as apply.

Tourism

School program

Business

See a Peace Corps volunteer or missionary

See relatives and friends

Missionary work

Health clinic work or drawing blood

Construction work

Camping

Teach Bible

Adopt a child

Other teaching. What subject matter?

Have sexual contact with local people

Geology, archaeology, or anthropology field work. Or work with rodents.

Other:

Rural evenings and nights: Do you expect to spend time in rural areas in the evening or at night?

yes no not sure

Mosquitoes: Think about your chances of mosquito bites. Think about whether you will sleep in a screened area or under bed nets. Think about your outdoor activities, especially evenings and nights. How much mosquito exposure do you expect?

a lot some not much hardly any none not sure

GO ON TO THE NEXT COLUMN, PLEASE

Animals: Circle your answer to this question: Do you expect to be bitten or scratched by stray dogs, local wild animals, or other animals on your trip?

No animal contact expected.

There is some possibility that I might have animal contact.

It's fairly likely that I might have animal contact.

Other. What?

Access to medical care: In some places, malaria is a problem. Even if you are very careful, you still might get malaria. If you think you have malaria, you need to get medical care. Often, they will want to prick your finger with a small needle to get a drop of blood. They can check that blood for malaria.

Think about where you are going. Will they have needles for pricking your finger that have been *sterilized* reliably?

certainly yes probably yes probably no no not sure

What would you like?

Do you already have a list of immunizations, prescriptions, and questions that need to be taken care of?

yes no not sure

If yes, what is the source of the list?

- ☐ Your own reading
- ☐ Trip or travel organizers
- ☐ School program, church, or missionary group
- ☐ Health department clerk
- ☐ Other:

IMPORTANT! Please read this carefully. Call us

now (don't wait til your appointment) to talk things over IF:

- You are going to Asia AND you were told that you need yellow fever vaccine OR
- You were told that you need cholera vaccine OR
- You are coming to Travel Clinic ONLY for yellow fever vaccine

Food and water: *Circle as many of the following as apply:* What kind of travel do you expect?

All with good sanitation. Food and water only from reliable tourist hotels, reliable tourist restaurants, homes of reliable friends, homes of reliable relatives, or other reliable sources. **No** food from street vendors.

Possibly some food or water with questionable sanitation.

Possibly buy food from street vendors.

Much contact with food or water that may not meet U.S. standards.

Do you have any guides or immunization instructions? Please bring them with you. Please list what you need (immunizations, prescriptions, questions to be taken care of) here:

Person answering questions on this form:

Date:

Thank you! See you in the Clinic!

GO ON TO THE NEXT COLUMN, PLEASE