afc URGENT CARE

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Mon - Fri: 8 AM - 8 PM
Sat & Sun: 8 AM - 5 PM

Travel Vaccination Questionnaire

PLEASE COMPLETE THIS FORM AND RETURN BY MAIL, FAX, OR EMAIL (Inbox@AFCFP.com)

Patient's Full Name: _____ Date of Birth: _____

Phone: _____ Email Address: _____ Sex: ☐ M ☐ F

Patient's Destination: _____ Dates of Trip: _____

Are you currently treated for any medical problems?	☐ Yes	☐ No	*If yes, explain below*
Have you had a significant medical problem in the past?	☐ Yes	☐ No	*If yes, explain below*
Could you be pregnant?	☐ Yes	☐ No	
Are you staying mostly in cities / tourist destinations?	☐ Yes	☐ No	
Are you going to spend time in a rural area?	☐ Yes	☐ No	
Are you going to spend time above 5000 ft?	☐ Yes	☐ No	
Are you going to work in the foreign country?	☐ Yes	☐ No	
Are you allergic to eggs or chicken products?	☐ Yes	☐ No	
Have you had any hypersensitivity or reaction to vaccinations?	☐ Yes	☐ No	*If yes, explain below*
Have you had Guillain-Barre Syndrome?	☐ Yes	☐ No	
Have you had all of your childhood vaccinations?	☐ Yes	☐ No	
Have you had a tetanus/diphtheria vaccination in the last 10 years?	☐ Yes	☐ No	
Have you had a measles vaccination (2 shots)?	☐ Yes	☐ No	
Have you had a polio vaccination as an adult ?	☐ Yes	☐ No	
Have you had a hepatitis A vaccination (2 shots)?	☐ Yes	☐ No	
Have you had a hepatitis B vaccination (3 shots)?	☐ Yes	☐ No	
Have you had a meningitis vaccination in the past 3 years?	☐ Yes	☐ No	
Have you had a typhoid vaccination in the past 2 years (if injected), or in the past 5 years (if oral)?	☐ Yes	☐ No	
Have you had a yellow fever vaccination in the past 10 years?	☐ Yes	☐ No	
Have you had a Japanese encephalitis vaccination in the past 2 years?	☐ Yes	☐ No	

List current or previous significant medical conditions: _____

List current medications: _____

List allergies: _____

Comments: _____

SIGNED: _____ **DATE:** _____