



Traveler's Immunization Center
Health Questionnaire/Risk Assessment

NOTICE: Vaccination and prophylactic medication decreases the likelihood of infection but does not entirely remove the risk of illness. Good personal health practices and behavior are essential for healthy travel.

PERSONAL INFORMATION

Name _____ Telephone _____

Birth date _____ Weight if under 12 years _____

Address _____ City _____ ZIP _____

e-Mail _____ Phone _____ Cell _____

Company (if business travel) _____

Company contact _____

MEDICAL HISTORY

Personal Physician _____ Phone _____

Address _____

Health Problems: (immune disorders, steroids, diabetes, chemotherapy, joint prosthesis, pacemaker, depression, fibromyalgia, anxiety, etc)

Regular Medications and supplements:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Allergies: (eggs, vaccines, bees, foods, medications) _____

Pregnant? Y N

Previous Immunizations/year:

Tetanus/Diphtheria	MMR	Polio	Varicella
Flu	Pneumonia	Typhoid	Yellow Fever
Meningitis	Hep A	Hep B	Rabies
Japanese Encephalitis	TB Skin Test		

Traveler's Immunization Center

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www.medtravdoc.com



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Trekkers: Previous altitude problems? Heart disease? Lung disease? Medical clearance for strenuous activity?

Divers: Recent plastic surgery or body piercing? DCI or hyperbaric treatments? Heart disease? Lung disease? Ear problems?

TRAVEL HISTORY

Travel Agent _____

Travel Medical and Evacuation Insurance _____

Departure Date _____

Return Date _____

List Country and specific locations in sequence:

- 1.
- 2.
- 3.
- 4.

Previous International Travel:

RISK ASSESSMENT

Cruise _____ Hotel Class 0 1 2 3 4 5 Stars
Hostels _____ Camping _____
Living with locals _____ Safari _____
Solo _____ Trekking _____
Healthcare or volunteer worker _____ Surfing _____
Diving _____ Rafting _____
Visiting friends and relatives _____ Zoological studies _____
Other risks _____



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QUESTIONS AND CONCERNS:

Vaccines, health precautions, insect protection and malaria prophylaxis are extremely helpful but do not guarantee illness prevention. **IF YOU BECOME SERIOUSLY ILL DURING OR UP TO A YEAR AFTER TRAVEL, IT COULD BE MALARIA. SEEK LOCAL CARE OR EVACUATION AT ONCE.** Contact your physician and Traveler's Immunization Center upon your return.

Medical Consent for Services: I understand that vaccines can in rare instances cause complications including death. I also understand that the chance of serious harm is less than 1 in 1,000,000 and that these vaccines and medications are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I also give permission for you to provide my personal physician with a list of vaccines that I have received. Traveler's Immunization Center does not accept any insurance.

Signed _____ Date _____
(Traveler, Parent or Guardian)

Please mail or fax at least 7 days before your appointment. Fax: 1-760-643-9399. Please be sure that all requested information is provided.

For documentation by physician and nurse

Td___ MMR___ VZ___ IPV___ YF___ MGC___ TYO___ Vi___
JE 1___ 2___ B___ HAV 1___ 2___ HB 1___ 2___ 3___
TwinRix 1___ 2___ 3___ IgG___ Rabies 1___ 2___ 3___ B___ Pneumo___ Flu___ PPD___

Malarone___ CQ___ Mef___ Doxy___ Prim___ Cipro___ ZITH DEET Perm Net Insects H2O Altitude
Schisto Accidents Alcohol Drugs Sex

(_+_ if needed, O if done)
NOTES: BP___ Temp___ Weight___