UNIVERSITY OF LOUISVILLE

UofL Vaccine and International Travel Center Health Questionnaire

Please Print Clearly

Name:_____ **Age:**____ **Weight:**_____ **DOB:**_____ **Sex: M F**
Last Name First Name MI MM/DD/YYYY

Home Address:_____ _____ _____ _____
Street Address City State Zip

Phone:_____ _____ **Email:**_____
Home or Cell Work

Employer:_____ **Occupation:**_____

Emergency Contact:_____ _____ _____
(required) Name Relationship Phone Number

Pharmacy Information

Pharmacy Name:	**Pharmacy Phone:**
Pharmacy Address:	

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:
- ◯ Leisure
- ◯ Adoption
- ◯ Study Abroad
- ◯ Business
- ◯ Missionary
- ◯ Other

Accommodations:
- ◯ Resort
- ◯ Cruise Ship
- ◯ Staying with Family/Relatives
- ◯ Hotel
- ◯ Rural Travel

Activities:
- ◯ Sightseeing
- ◯ Camping
- ◯ Business Meetings
- ◯ Climbing/Hiking
- ◯ Safari

Who arranged your Trip: _____ _____
Name Phone

Immunization History:

1) Have you had your 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 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:

_____

_____

5) Please list any vaccines you have received in the past 30 days:

_____

Do you have heart problems?	Yes	No	Are you allergic to bee stings?	Yes	No
Do you have high blood pressure or take high blood pressure medicine?	Yes	No	Do you have diabetes? If yes, do you take insulin? ☐ Yes ☐ No	Yes	No
Do you have bleeding problems, take anticoagulants, aspirin, or aspirin therapy?	Yes	No	Do you have tuberculosis, or tested positive for tuberculosis?	Yes	No
Do you have lung problems, asthma, or chronic bronchitis/shortness of breath?	Yes	No	Do you have a history of depression, anxiety, or other psychiatric disorder?	Yes	No
Are you currently taking antibiotics?	Yes	No	Have you ever had a seizure, convulsion, epilepsy, neurological condition, or brain infection?	Yes	No
Are you currently experiencing any respiratory infections or other acute illness or infections?	Yes	No	Do you have a history of Guillian-Barre Syndrome?	Yes	No
Do you have any skin conditions (e.g., psoriasis)?	Yes	No	Are you prone to motion sickness?	Yes	No
Do you experience nightmares or insomnia?	Yes	No	Are you allergic to eggs, yeast, or any other foods?	Yes	No
Do you any immune system problems, such as cancer, HIV, or AIDS?	Yes	No	Do you take any cortisone, prednisone, steroids, chemotherapy, or other biologic (e.g., Humira, Remicade, etc.)?	Yes	No
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge Syndrome, or thymoma?	Yes	No	Do you have any eye conditions (e.g., glaucoma)?	Yes	No
Do you have stomach/bowel conditions, such as frequent diarrhea, constipation, or irritable bowel syndrome?	Yes	No	Have you ever fainted from an injection or from having your blood drawn?	Yes	No
Do you smoke?	Yes	No	During the past three (3) months, have you received a transfusion of blood or plasma, or been given immune globulin?	Yes	No
Do you drink?	Yes	No	Do you have ANY other health issues for which you see a health professional? Please describe: _____ _____ _____		

Are you allergic to latex, any drug, medication, vaccine or vaccine component, thimerosol, protamine sulfate, or mercury (a preservative)?
☐ Yes ☐ No
If yes, what are you allergic to? _____
_____

Are you currently taking any medications (including oral contraceptive)?
☐ Yes ☐ No
If yes, please list all medications you are currently taking or will be taking during your trip:
_____
_____
_____

Questions for Women:	Yes	No
Do you use a contraceptive or birth control (e.g., condoms, pills, surgical sterility)?	☐	☐
Are you pregnant?	☐	☐
Do you plan to become pregnant in the next three (3) months?	☐	☐
Are you currently breastfeeding (nursing)?	☐	☐

How did you hear about the UofL Vaccine and International Travel Center?

☐ Established Client ☐ School/College ☐ Physician ☐ Employer ☐ CDC Website
☐ Friend/Relative ☐ UofL Website ☐ Travel Agent ☐ Other _____

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, even if I submit receipts for reimbursement. The Vaccine and International Travel Center will provide me with an itemized statement of services rendered. 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 Our Office:

UofL Vaccine and International Health and Travel Center
UofL Ambulatory Care Building, 2nd floor
550 South Jackson Street
Louisville, KY 40202
502-562-2822

From Louisville I-64 West

3rd Street Exit
3rd Street to Chestnut Street – Turn Left onto Chestnut Street
Travel down Chestnut Street 6 blocks to Jackson Street
Turn Left onto Jackson Street
The UofL Ambulatory Care Building is located on your left.

From Indiana I65 South

Jefferson Street Exit
Jefferson Street to 1st Street – Turn Left onto 1st Street
Travel 2 blocks - Turn Left onto Chestnut Street
Travel four blocks — Turn Left onto Jackson Street
The UofL Ambulatory Care Building is located on your left.

From Louisville I-65 North

Broadway exit
At the end of the ramp, go straight through the traffic light
Go 2 blocks – Turn Right on Chestnut Street
Travel down Chestnut Street through 2 traffic lights
At the 3rd traffic light (Jackson Street) — Turn Left onto Jackson Street
The UofL Ambulatory Care Building is located on your left.

Note: You have several parking options.

Meters are located on the streets surrounding the building. You can also park in the parking garage located on Jackson Street next door to the Ambulatory Care Building. If you park in the garage, there is a walkway on the 2nd level that brings you into the 2nd floor of the Ambulatory Care Building. Enter the building through the glass doors, walk to the end of the entrance way and turn right. You will now be in the Ambulatory Care Building. Follow the signs to the Vaccine and International Health and Travel Center located in the 550 Clinic.

Handicap parking is available in the parking garage.