INTERNATIONAL MEDICINE CENTER (IMC)
Traveler Information Form (TIF) (Last Modified 05/12/2016)

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MD2

DATE_____

To reduce the amount of time you spend in our office, fill out this form and return it to our office **BEFORE SCHEDULING YOUR APPOINTMENT.** FAX, mail, or deliver this form and, if available, your **International Certificate of Vaccination** World Health Organization yellow booklet to us at the FAX number/address above. **Please Print.**

Referred by: ☐ Employer ☐ Physician _____ **☐ Angie's List ☐ Prime Living Magazine ☐ IMC Website ☐ Postcard ☐ Zoc Doc**
☐ Houston Modern Luxury ☐Houston Safari Club ☐ Safari Club International ☐ Other: _____

TRAVELER INFORMATION

NAME: LAST_____ FIRST_____ **AGE**_____
HOME ADDRESS_____ **DOB**_____
CITY_____ STATE_____ ZIP_____ MALE FEMALE
HOME PHONE ( ) _____-_____ WORK PHONE ( ) _____-_____ EMAIL_____
CELL NUMBER ( ) _____-_____ SS#_____-_____-_____ FIRST TIME IMC CLIENT? Y N
EMPLOYER_____ COST CTR./JOB NO._____
☐ FORMAL COMPANY EMPLOYEE ☐ SUBCONTRACTOR ☐ CONSULTANT **LAST IMC VISIT (MO/YR):**_____
☐ INVOICE COMPANY ☐ CORPORATE CREDIT CARD ☐ PERSONAL CREDIT CARD SUPERVISOR_____

TRAVEL INFORMATION

OCCUPATION_____ **REASON** FOR TRAVELING: ☐ LEISURE ☐ BUSINESS
DESTINATION(S) (City/Country) _____
_____
ACCOMMODATIONS **CITY**_____ **RURAL**_____ **FREQUENT/RECURRENT INT'L TRAVELER? ____N ____Y:**___Rotation ___Expatriate
DEPART. DATE_____ **LENGTH OF STAY/ROTATION**_____

IMMUNIZATION HISTORY

Next to each immunization:
- **write the month/year inoculated, or "+" if time unknown.**
- **write "Hx" if you had the disease,**
- **write "?" if unsure whether you were inoculated**

____ BCG (TB Prevention)
____ Chickenpox (Varicella)
____ DPT/DTaP
____ Hepatitis A - series of 2 shots
____ Hepatitis B - series of 3 shots
____ Influenza
____ Japanese Encephalitis
____ Measles
____ Measles Mumps Rubella (MMR)
Meningococcal:
____ Menactra/ Menveo
____ Menomune
____ Mumps
____ Pneumococcal: ___Prevnar ___PneumoVax
____ Polio/Injectable (IPV)
____ Polio/Oral (OPV)
____ Rabies
____ Rubella (German Measles)
____ Shingles/Herpes zoster (50 yrs or older)
____ Tetanus Toxoid
____ Tetanus/Diptheria (Td)
____ Tdap (tetanus, diptheria, activated pertussis)
____ Tuberculin Skin Test (PPD)
____ Typhoid Injectable (Typhim Vi)
____ Typhoid Oral
____ Yellow Fever
____ OTHER:

UNUSUAL/ADVERSE REACTIONS TO THE ABOVE_____
Have you had any immunizations in the last 30 days? N Y
Do you have an International Certificate of Vaccination (yellow booklet)? N Y
FORWARD IMC records to my personal physician N Y PHYSICAL EXAM REQUIRED?: **N Y** _____**(type)**
☐ COMMUNICATE my medical information to me by ☐ mail ☐ FAX ☐ email*

MEDICAL HISTORY

MEDICATIONS: Do you take any medications on a **regular basis,** either prescription and/or non-prescription medications? **Yes**_____ **No**_____

Prescription:*
_____
_____
Non-prescription:
ALLERGIES/REACTIONS: **None** ____
Medications:
Eggs:
Latex:**

*No decreased for vaccine response w/ prednisone, hydroxychlor, sulfasalazine, or anti- TNFs

Should not use vaccine vials/syringe with **natural rubber, dry **natural** rubber, or rubber latex:

Fainting/Dizziness Tendency With Needles: **Y N**

Other:
_____
_____
_____

PHYSICIAN VISIT Date_____
Discussed with patient,
___Sleep med ___Pain med (proper use)
___Other:_____

Will you need a **Travel Medicine Kit?**** **Y N**
Basic ☐ Full ☐ Full Kit #2 ☐
Will you need a **Bloodborne Pathogen Protection Kit?**** **Y N**
Will you need **meds** for ___**Pain** ___**Sleep**?
Form Completed By:_____

HISTORY OF ACTIVE/CHRONIC:

	Yes	No
Asthma/Smoker		
Blood clotting tendency/pulmonary embolism/vein thrombosis		
Cancer: _____ Type		
Diabetes Mellitus		
Guillain-Barre' Syndrome		
Glaucoma		
Heart/Lung Disease		
1. Congenital/Familial QT Interval Syndrome		
2. Heart rhythm problems		
3. Severe Heart Disease		
Hypertension		
Immune Deficiency:_____ Type		
Liver Disease		
Motion Sickness		
Neurological Disorders/History		
Shingles		
Surgery (recent):_____		
Psychiatric Disorders/Depression		
Thymoma/ThymectomyMyastheria gravis/Splenectomy		
Other:		

Marital Status: S_____ M_____ Sep_____
Women Only: PREGNANT(or attempting)** **Y N**
Breastfeeding?** **Y N**
**avoid pregnancy at least 4 weeks post – vacc.

STAFF ONLY:

WEIGHT_____ Height_____ BP_____ T_____ HR_____ R_____
Medication/Kit Orders_____
< 18 yrs old: Has **Guardian Consent** For Treatment **Y N**
☐ Client informed insurance NOT ACCEPTED
___ Record in **IMC TRACKING LEDGER** as Travel Consult:_____ **Initials** (done)
APPOINTMENT TIME_____ **DATE**_____
***PROVIDE email Policy/Informed** Consent Packet

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