

**AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY**

Name: Courtney Mitchell Date: 08/26/2018
MM DD YYYY

1. What is the reason for your visit today? Immunizations
2. List allergies you have to medicines, foods, or iodine: N/A
3. List any medications or drugs you are currently taking (this would include herbal and over-the counter as well as prescription drugs): N/A
4. Have you had any of the following (circle all that applies):
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised (is there a problem with your immune system)?
____ Yes ☒ No
Do you have **Thymus disorder** (myasthenia gravis, thymoma, thymectomy)?
____ Yes ☒ No
Have you had your **spleen removed**?
____ Yes ☒ No
Are you a **transplant recipient**?
____ Yes ☒ No
Do you have **cirrhosis of the liver**?
____ Yes ☒ No
Do you have **cancer**?
____ Yes ☒ No
Do you have **HIV**?
____ Yes ☒ No
6. How often do you drink beer, wine, wine coolers, or liquor? Please circle the answer.
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Afghanistan
8. How long is your trip? Months 12 Days _____
9. When are you leaving on your trip? August

FOR FEMALES ONLY

1. Date of your last period? 7/23/18 Have you had a hysterectomy? ____ Yes ☒ No
2. Are you currently pregnant? ____ Yes ☒ No
If yes, when is your due date? _____
3. Do you plan to become pregnant in the next 3 months? ____ Yes ☒ No
4. Are you breastfeeding? ____ Yes ☒ No

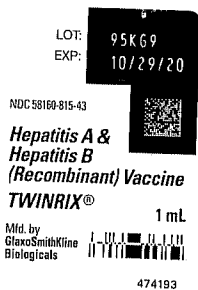
Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Carterney Mitchell
DATE OF BIRTH 08/04/1989
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Carterney Mitchell DATE 07/26/18
FORM REVIEWED BY [Signature] DATE 7/26/18



Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

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Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (4/18)