Name: _____ D.O.B: _____

MEDICAL AND ALLERGY INFORMATION

What is your medical history and current status? (past illnesses and surgeries, chronic health problems or underlying medical conditions)

Are you sick today?

What medications are you currently taking or have you taken in the past 3 months?

Are you immune deficient or in close contact with anyone who has cancer or is otherwise immunosuppressed?

Do you have a history of depression or psychiatric disorders?

Have you ever had headaches, dizziness or felt very short of breath when at altitudes above 6000 feet?

Are you prone to motion sickness?

Please check if you are allergic to any of the following medications: ( ) Penicillin ( ) Sulfa ( ) Neomycin ( ) Polymixin ( ) Streptomycin ( ) Amphotericin B ( ) other

Please check if you are allergic to any of the following: ( ) eggs ( ) yeast ( ) gelatin ( ) animal protein ( ) feathers ( ) latex ( ) bee stings ( ) other

Have you ever fainted from an injection or from having your blood drawn?

Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination?

During the past three months, have you received a transfusion blood or plasma, or been given medicine called immune globulin?

Have you received any vaccinations in the past 4 weeks? Please list:

If you are female are you pregnant or do you plan to get pregnant in the next 3 months?

IMMUNIZATIONS

If you are not currently a patient at Ridgefield Pediatrics please mail or fax back with this questionnaire a copy of all immunizations received in the past.
The above information is accurate to the best of my knowledge. I understand that insurance may not cover travel immunization services and I am responsible for all fees associated with the visit. Payment is due at the time of service by credit card, cash or check.

Traveler/Parent/Guardian Signature:

_____ Date: _____

AMW