The International Travel Clinic
PEDIATRIC PATIENT INFORMATION

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ____

BIRTH DATE: _____/_____/_____ GENDER: MALE_____ FEMALE_____
(Month) (Day) (Year)

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____ZIP: _____

TELEPHONE NUMBERS: Day: _____ Evening _____

Fax: _____ E-Mail: _____

PARENTS/GUARDIANS:

_____

Who referred you to our office? _____

Primary care physician _____ Telephone number _____

Do you want us to notify your physician of this visit? Yes ____ No _____

In case of emergency, whom should we contact? _____Telephone:_____

Where were your child born?

_____

How long have you been living in South Florida? _____

Have you traveled overseas before? Yes ___ No ___

List countries to which you traveled before:

_____

_____

_

THIS TRIP: Date of departure: _____
Location: Rural ____ Urban _____ Both _____

List countries of travel and length of stay in each this time:

1. _____ 2. _____

3. _____ 4. _____

5. _____

PERSONAL HISTORY

When did the pediatrician last see your child? _____

Does your child have any chronic medical problems? Yes ___ No ___

Does your child have a medical condition that is stable now, but that may recur while traveling?
Yes ___ No ___ Explain: _____

Does your child take any medications regularly? Yes ___ No ___
If yes, explain _____

Has your child ever been hospitalized? Yes ___ No ___
If yes, explain _____

Has your child had any transfusions of blood or blood products? Yes ___ No ___

Has your child had any operations? Yes ___ No ___

Date of last menstrual period (if applicable) _____

Has your child had all the necessary immunizations? Yes ___ No ___

ALLERGIES/SENSITIVITIES

Has your child had any allergic reactions? Yes ___ No ___
If yes, explain _____

Allergies to	**YES**	**No**		**Yes**	**No**
Eggs	___	___	Yeast	___	___
Dairy products	___	___	Soy, wheat	___	___
Beef	___	___	Fish	___	___
Gelatin	___	___	Sulfites	___	___
Mercury or thimerosal	___	___	ANY medications	___	___
Describe: _____			Penicillin	___	___
Sulfa Drugs	___	___	Mycine	___	___
Other antibiotics	___	___	Aspirin	___	___
Codeine	___	___	Tetanus	___	___
Antitoxin	___	___	Serums	___	___
Adhesive tape	___	___	Insect bites	___	___

IMMUNIZATIONS

Have you had	**YES**	**NO**	**DATE**
Tetanus	___	___	_____
Diphtheria	___	___	_____
Pertussis	___	___	_____
H. influenzae type B	___	___	_____
Chickenpox (Varicella)	___	___	_____
Hepatitis A	___	___	_____
Hepatitis B	___	___	_____
Measles	___	___	_____
Mumps	___	___	_____
Rubella	___	___	_____
PPD	___	___	_____
Influenza	___	___	_____
Pneumococcus (pneumonia)	___	___	_____
Polio	___	___	_____
Rabies	___	___	_____
Cholera	___	___	_____
Typhoid	___	___	_____
Japanese Encephalitis	___	___	_____
Meningococcal	___	___	_____
Plague	___	___	_____
Immune Globulin	___	___	_____
Yellow fever	___	___	_____

Other:

_____

_____

Signature of person completing questionnaire

_____

WEIGHT: _____

Physician's Notes:

_____

_____

_____