STANFORD HOSPITAL & CLINICS
Stanford University Medical Center

Tropical Medicine and Travelers' Health Clinic
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Phone: (650) 736-5700 Fax: (650) 725-6908
Email form to: SHCTravel@stanfordhealthcare.org

Travel Form

Affix Label here

Name:	Date:	Phone: email:
Department/Group Sponsoring trip:		Date of Birth:
Departure date:	Arrival date at first destination:	

Please complete both pages of this form and return via email or fax at least one week before your appointment. Please remember to bring all vaccination records with you to your appointment.

Medical history (include any past medical or surgical history; particularly important are: HIV/AIDS, leukemia, lymphoma, or any other cancer, organ or bone marrow / stem cell transplantation, heart or lung disease or arrhythmias, psychiatric conditions, kidney or liver problems, disorders of the thymus gland, splenectomy, other immunological disorders, current pregnancy or breastfeeding.)

_____

_____

1. List Allergies (list all, but especially important are allergies to eggs, neomycin, antibiotics, vaccine or vaccine components, or other medications.)

2. List all medications you are currently taking or have taken in the past year. Please list all; particularly important are blood thinners such as coumadin / warfarin, corticosteroids such as prednisone, and chemotherapy agents for cancer or other conditions.

3. Have you had any serious reaction to vaccinations in the past? Yes☐ No☐

4. Do you have a specific question about your trip?

5. Will you be traveling to altitudes above 8,000 ft. (2,400 m.)? Yes☐ No☐

6. Is there a chance you are pregnant? Yes☐ No☐

Please list your complete itinerary. Include all stopovers in chronological order, dates of itinerary and what you will be doing (i.e., sightseeing, business research, exposure to animals, health care work, visiting friends and relatives).

Location (country)	Specific Locale	Date of Travel			Purpose
1.			to		
2.			to		
3.			to		
4.			to		
5.			to		
6.			to		
7.			to		
8.			to		
9.			to		
10.			to		

	Immunization Name	Dose #1	Dose #2 (if applicable)	Dose #3 (if applicable)
Childhood	Hepatitis A			
	Hepatitis B			
	Twinrix (Hep A & Hep B)			
	Polio (Last Dose)		**Check One:**	___ Oral ___ Injected
	Meningococcal			
	DTP/Tetanus (TD)/Tdap			
	Measles, Mumps, Rubella (MMR)			
	Varicella			
	Pneumococcal			
	Human Papilloma Virus (HPV)			
	Rotavirus			
Travel	Influenza			
	Japanese Encephalitis			
	Rabies			
	Typhoid		**Check One:**	___ Oral ___ Injected
	Yellow Fever			
Other	Zostavax			