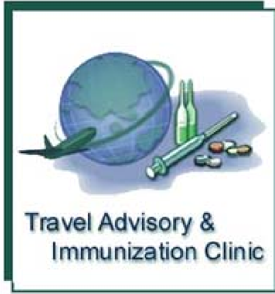

ROUTINE ADULT IMMUNIZATIONS

TRAVEL ADVISORY AND IMMUNIZATION CLINIC

15005 Shady Grove Rd., Suite 450
Rockville, Maryland 20850
Office: (301) 738-6420 Fax: (301) 738-2215

NAME: ________________________________ DATE OF BIRTH: ______________

OCCUPATION: ____________________________ SEX: FEMALE _____ MALE _____

ADDRESS: ______________________________ HOME PHONE: ________________

______________________________ WORK PHONE: ________________

______________________________ CELL PHONE: ________________

REFFERED BY:

- ☐ SELF – REFERRAL
- ☐ HEALTH DEPARTMENT
- ☐ INSTITUTION: ______________________________
- ☐ PHYSICIAN: ______________________________
- ☐ OTHER: ______________________________

REASON FOR VISIT:

_____ **Gardasil-HPV**	_____ **MMR (Measles, Mumps, Rubella)**	_____ **Zostavax (Shingles)(+Hx of CP)**
_____ **Hepatitis A**	_____ **Pneumovax**	_____ **Tuberculosis test (PPD)**
_____ **Hepatitis B**	_____ **Polio**	_____ **Other :**
_____ **Influenza(Nasal/Inj)**	_____ **Tetanus/diphtheria**	______________________
_____ **Twinrix (Hep A & B)**	_____ **Tetanus/Diptheria/Pertussis**	______________________
_____ **Meningococcal-MCG**	_____ **Varivax (Chicken Pox)**	

I understand that the Travel Advisory and Immunization Clinic is NOT affiliated with any insurance company and does NOT accept insurance reimbursement for services rendered. I also understand that I am responsible for the total amount of charges for any services requested.

We accept: VISA, MasterCard, & American Express
-OR-
Checks (for services under $200)

Signature: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ________________

MEDICATIONS	List Medication(s) You Are Now Taking	VACCINES, DRUG & FOOD ALLERGIES	
	______________________		______________________
	______________________		______________________
	______________________		______________________
	______________________		______________________
	______________________		______________________
	______________________		______________________

Medical History	Current Medical Problems (Possible Contraindications)

- [ ] Lungs (Asthma/ COPD/ Chronic Bronchitis): ______________________
- [ ] Autoimmune Disorder (RA / Lupus): ______________________
- [ ] Neurological (Multiple Sclerosis, Guillain Barré, Etc): ____________
- [ ] Cancer Treatment: ______________________
- [ ] Seizure/Loss of Consciousness: ______________________
- [ ] Immunosuppresive Drugs: ______________________

Other pertinent medical information: ______________________

____

____

____

Name of Personal Physician: ______________________

Women Only	Please answer the following questions.

Are you pregnant or do you suspect you may be pregnant? _____Yes _____ No

Do you plan to become pregnant within 3 months? _____Yes _____ No

Name: ______________________ Date: ______________

For Office Use Only

Name: ______________________________ Date: ________________

MASTER IMMUNIZATION RECORD							
DATE	VACCINE	DOSE	ROUTE	LOT NO.	EXP. DATE	VIS DATE	SIGNATURE
	GARDASIL	1.0cc	IM				
	GARDASIL	1.0cc	IM				
	GARDASIL	1.0cc	IM				
	HEPATITIS A	1.0cc	IM				
	HEPATITIS A	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	HEPATITIS B	1.0cc	IM				
	INFLUENZA	0.5cc	IM				
	INFLUENZA	0.5cc	IM				
	POLIO, INJ.	0.5cc	IM				
	Meningococcal (MCG)	0.5cc	SC				
	Meningococcal (MCG)	0.5cc	SC				
	Measles, Mumps, Rubella	0.5cc	SC				
	Measles, Mumps, Rubella	0.5cc	SC				
	Tetanus/Diphtheria	0.5cc	IM				
	Tetanus/Diphtheria	0.5cc	IM				
	Tdap	0.5cc	IM				
	Tdap	0.5cc	IM				
	Varivax (Chickenpox)	0.5cc	SC				
	Varivax (Chickenpox)	0.5cc	SC				
	Zostavax (Shingles)	0.5cc	SC				

TUBERCULOSIS SKIN TEST OR ANTIBODY SKIN TEST					
DATE	TEST NAME	RESULT	DATE	TEST NAME	RESULT

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