



ROUTINE ADULT IMMUNIZATIONS TRAVEL ADVISORY AND IMMUNIZATION CLINIC

2301 Research Blvd, Suite 125

Rockville, Maryland 20850

Office: (301) 738-6420 Fax: (301) 990-3534

NAME: _____ DATE OF BIRTH: _____
OCCUPATION: _____ SEX: FEMALE _____ MALE _____
ADDRESS: _____ HOME PHONE: _____
_____ WORK PHONE: _____
_____ CELL PHONE: _____

REFERRED 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/Diphtheria/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: _____
- Immunosuppressive 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: _____

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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