PATIENT'S MEDICAL HISTORY FOR TRAVEL PATIENTS

Patient Name: _____ DOB: _____

MEDICATION HISTORY

Please list ALL the medications both prescription & over-the-counter,

and vitamins, minerals that you are currently taking

Name	Strength	Direction

ALLERGIES

Are you allergic to any medications? YES or NO

Are you allergic to Latex? YES or NO

Name	Reaction

VACCINATION HISTORY

VACCINATION	YES	NO	REFUSED
Influenza (Between September 1- March 31)			
Pneumonia (Age 65 and Over)			
Shingles (Age 50 and Over)			
Hepatitis A			
Hepatitis B			
Typhoid			
Tdap			
MMR			
Meningitis			

MEDICAL HISTORY

List Major Injuries or Illnesses	Date

Patient's Signature: _____ Date: _____