ATLANTA TRAVEL MEDICINE

Medical History

* **Date**: _____ * (Required field)

* **Name**: _____ * **DOB**: _____

New or Established Travel Patient? ● New ○ Established

Current/Ongoing Medical Conditions

Past/Resolved Medical Conditions and Surgeries

Do you have any condition which has or could lower your immune system? ○ **Yes** ○ **No**

If yes, please explain: _____

Are you pregnant, could you be pregnant, or are you trying to become pregnant? ○ **Yes** ○ **No**

Are you breastfeeding? ○ **Yes** ○ **No**

Current Medications with Dosage

Allergies (check any of the following to which you are allergic):

☐ Eggs ☐ Thimerisol ☐ Sulfa ☐ Neomycin ☐ Streptomycin
☐ Beestings ☐ None ☐ Other _____

Vaccine History: please note any of the vaccinations or diseases you have had below, with dates, if possible.

Disease Name	Date Of Disease (MM/YYYY)	Date Of Vaccine (MM/YYYY)
Measles (rubeola)		
Mumps		
Rubella (German measles)		
Chicken Pox (varicella)		
Hepatitis A		
Hepatitis B		

Have you received at least 3 doses of tetanus/diphtheria (Td) vaccine in the past (includes DPT doses as a child)? ○ **Yes** ○ **No**

When was your last tetanus/diphtheria shot given? _____

Have you received at least 3 doses of polio vaccine, including any childhood doses? ○ **Yes** ○ **No**

Last dose date: _____

Other vaccines with dates not listed above (pneumococcus, influenza, rabies, small pox, etc): _____

What vaccinations do you need to update?

☐ Typhoid ☐ Yellow Fever
☐ Malaria ☐ Other Prescriptions

_____ _____ Date: _____

Signature Signature (Parent /Guardian of Minor)

Print Clear Save

Due to HIPAA regulations, we cannot accept medical history forms online.
Please fill out, print and fax to our office at 404-459-0003 or bring with you to your visit,
along with any immunization records you may have.

Atlanta Travel Medicine, L.L.C, 5673 Peachtree Dunwoody Road, Suite 330, Atlanta, Georgia 30342, Phone: 404-941-1317