NAME: Allergic to medication:

DATE: Allergic to EGGS YEAST

Complete YEAR in EVERY section. If the answer is ? or never, indicate that.

I was born in (country) _____			
I received childhood immunizations	Yes	No	
I moved to the USA in (year)_____			
I currently live in (countries)_____			

WE RECOMMEND THE FOLLOWING SHOTS, EVEN IF NOT TRAVELING			
	YEAR	COMMENTS	Office use
Year of last **TETANUS** shot. Need every 10 years.			
Year of last **MEASLES/MUMPS/RUBELLA (MMR)** shot. **CANNOT HAVE IF PREGNANT. Must wait 28 days to get pregnant after shot. Probably cannot have if EGG allergy**. Need one shot if born after 1957.			
Year of last "**FLU**" shot. Need every year. **Cannot have if EGG allergy.**			
Year of last "**PNEUMONIA**" shot. Need every 5 years after age 55.			
Year I had CHICKEN POX DISEASE. Don't need shot.			
Year of **CHICKEN POX** shot.			
Year completed 3 shot series for **HEPATITIS B**. **Cannot have if YEAST allergy.**			
Year completed 2 shot series for **HEPATITIS A**.			
Year of last **MENINGITIS** shot. Need every 2 years for dormitory living.			

TUBERCULOSIS (TB): In the USA we do not use BCG. If you have had BCG you can still get tuberculosis, so we want to test you. If you have had a positive test for TB you need to be treated!!			
Month/Year of last TB TEST (shot or prongs)			
Results of TB test			
Year and number of months treated for TB			
Year I had BCG shot for TB			

THESE SHOTS ARE RECOMMENDED OR REQUIRED FOR TRAVEL			
Year of last **YELLOW FEVER** shot. **ABSOLUTELY CANNOT have if EGG allergy or over age 70.** REQUIRED for Africa and South America. Need every 10 years			
Year of last **TYPHOID** shot or pills. Recommended every 2 years, including Mexico but not Europe.			
Year of **POLIO SHOT**, not by mouth. Recommended one-time shot (in addition to childhood shots), including Europe.			
Year completed 3 shot series for **RABIES**. Need booster every 2 years for personal contact with animals.			
Year of last **MENINGITIS** shot. REQUIRED for Haj. Recommended for Africa. Need every 2 years.			
Year of last **JAPANESE ENCEPHALITIS**. Rarely needed.			

I understand that the information I have provided above will be used to determine what immunizations I receive. The information provided is accurate.

Print your name. Signature:

Relationship to patient: Date: