BROWARD MEDICAL & URGENT CARE

TRAVEL CLINIC

Fort Lauderdale

YELLOW FEVER VACCINE QUESTIONNAIRE

PATIENT INFORMATION: PLEASE PRINT ALL ANSWERS

Patient Name (exactly as it appears on passport): _____

Date of Birth: _____/___/_____ Age: _____ Gender (circle): Male or Female
MM / DD / YYYY

Street Address: _____

City: _____ State: ____ County: _____ Zip: _____

Phone Number: _____ Email: _____

Emergency Contact Information: Name: _____

Relation: _____ Phone Number: _____

FOUND BY: Search Engine/Website _____ **REFERRED BY**: Person _____
Google/Yelp/CDC/Web MD/Etc

Primary Physician (name): _____ City: _____ State: _____

Pharmacy Name & Address/location:_____

Please answer all the following questions regarding medical conditions and history:

1. Have you ever received a yellow fever vaccine before? _____ Yes ___ No If no, proceed to question 2, If yes, please answer the following questions:

1a. What was the date of your last yellow fever vaccine: _____

1b. Were you pregnant at the time of your last yellow fever vaccine? _____ Yes ___

No

1c. Have you received a booster dose since then? _____ Yes ___ No

1d. Have you received a hematopoietic stem cell transplant since your last yellow fever vaccine? ____ Yes ___ No

1e. Are you HIV positive? _____ Yes ___ No

1f. Did you have an allergic reaction to your previous yellow fever vaccine? _____ Yes ___ No

2. Have you received a vaccine in the past 30 days or are planning to receive a vaccine in the next 30 days? ___ Yes ___ No

2a. If yes, which vaccines?

_____

3. Are you severely allergic to eggs or any component of the yellow fever vaccine? _____ Yes ___ No

4. Have you ever had a reaction to any previous vaccinations? _____ Yes ___ No

5. Are you currently pregnant or planning to become pregnant? _____ Yes ___ No

6. Are you breastfeeding? _____ Yes _____ No

7. Have you been diagnosed with HIV? _____ Yes ___ No

7a. If yes, are you considered currently symptomatic or have a CD4+ T-lymphocyte count of <200/mm3? ____ Yes ___ No

8. Have you ever been diagnosed with a thymus disorder? (Including: myasthenia gravis, DiGeorge Syndrome, thymoma, or thymectomy): _____ Yes ___ No

9. Have you ever received an organ transplant? (Including: bone marrow transplants in the past 2 years or any solid organ transplant) __ Yes _____ No

9a. If yes, when did the transplant occur? _____

9b. Are you still taking immunosuppressive drugs related to the transplant? _____ Yes ___ No

10. Have you ever been diagnosed with an immune deficiency or cancer? _____ Yes ___ No

10a. If yes, are you currently on any immunosuppressive therapies? (This includes but is not limited to: alkylating agents, TNF- α inhibitors, interleukin blocking agents, monoclonal antibodies targeting immune cells, and long term (>14 days), high dose, oral corticosteroids):_____ Yes ___ No

11. Have you currently or recently received radiation therapy? _____ Yes ___ No

12. Do you have any additional medical conditions not covered above? _____ None

13. Please list all medications you are currently taking (including any over the counter medications or supplements): _____ None

Please request an additional sheet if needed

14. Please list any allergies or reactions to medications, food, vaccines, insects, etc: _____ None

Please read and initial the below statements:

_____ I understand that this request is for the yellow fever vaccine only, and that I should seek out a full travel consult for a complete set of recommendations for my trip including malaria prophylaxis medications, necessary maintenance medications for the duration of my travels, and any other vaccinations or medications that might be indicated for the location(s) I am visiting.

_____ I have read, or had explained to me, the most up-to-date Vaccine Information Statement per the CDC for the yellow fever vaccine and understand the risks and benefits. I have been provided an opportunity to ask questions and they were answered to my satisfaction. I wish to receive the vaccine and hereby give my consent to receive the vaccine and for the provider to communicate the administration of the vaccine to my primary care practitioner, who is listed above. I have read the posted copy of the Patient's Privacy Policy (a copy is available upon request).

Signature of Patient/Guardian: _____ Date: _____

Print Name: _____

(If Guardian print *Name on behalf of Patient's Name*)

ACKNOWLEDGMENT OF NOTICE

By signing this I understand that I am financially responsible for all charges including medication, laboratory test and/or procedure(s) received and/or performed.

PRIVACY PRACTICES: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

MALPRACTICE INSURANCE: Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. **DR. MARTIN M. ROCHE, SR. MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This notice is provided pursuant to Florida law.

Signature of Patient/Guardian: _____ Date: _____

PLEASE COMPLETE THIS ENTIRE FORM BEFORE RETURNING IT TO OUR STAFF

THANK YOU