HUDSON TRAVEL MEDICINE, PC

MEDICAL HISTORY FORM

Thomas J. Rush, MD ▪ Harish Moorjani, MD ▪ Nili Gujadhur, MD
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127 Woodside Ave. Briarcliff Manor, NY 10510
Phone: 914 762-2276 ▪ Fax 914 762-2894

Date:___________________

Patient Name: ______________________________ Referring Doctor.: _______________________________

Medical History

Immunization (these include childhood vaccinations), please **circle "Yes" or "No"** to the following questions:

• Had rubella (German Measles) or received rubella vaccine?	Yes	No
• Had mumps or received mumps vaccine?	Yes	No
• Had measles or received measles vaccine?	Yes	No
• Have you received at lest 3 doses of polio vaccine?	Yes	No
• When was your last polio vaccination?	________________	
• Which polio vaccine did you receive?	Oral	Injectable
• Did your last Tetanus shot include Diphtheria?	Yes	No
• Have you had Hepatitis B vaccine?	Yes	No
• When did you receive your last Tuberculin Test?	________________	
• Have you received the BCG vaccine for Tuberculosis?	Yes	No
• Have you ever had reactions to immunization?	Yes	No

Do you have any allergies to the following items? (Circle all that apply)

Eggs	**Medicine**	**Antibiotics**	**Mercury (thimerosal)**	
Feathers	**Sunlight**	**Grasses or Molds**	**Vaccines**	**Formaldehyde**

Are there any other drugs to which you have had an allergic reaction? (Please list)

____

Are you being treated for **leukemia, lymphoma, cancer or any other malignant disease?**	Yes	No
Do you have a history of deficiency of the immune system?	Yes	No
Do you have a history of anemia or any other blood disorder?	Yes	No
Do you have any existing medical condition such as diabetes, heart disease or pulmonary disease?	Yes	No

If so, please list:____

Are you on steroids?	Yes	No

When was your last X-Ray performed? ____________________________

For Women Only:

Are you pregnant, suspect you may be pregnant or trying to become pregnant?	Yes	No

List all medications you are taking: ____

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Patient:_______________________________________

Date of Departure:____________________ Date of Return:_______________________

Who else are you traveling with?____

Please list in order of visitation the countries you are traveling and the length of stay in each country.

____________________________, ____________________________, ____________________________,
____________________________, ____________________________, ____________________________

Please circle all that apply to your travel plans:

Major Resort Hotels   Cruise Ships   Camping   Rural Travel at any time   Staying with a family
Small Hotels   Safari   Outdoor Activities   Rented foreign home   Youth hostel
Other____

What is the purpose of travel?   **Business**   **Teacher**   **Vacation**   **Student**
Missionary   **Volunteer Agency**   **Other__________________**

Please circle all the travel vaccines you have had:

Typhoid (Oral or Injectable)	Hepatitis A	Flu Vaccine	Doxycycline	Measles
Polio (Oral or Injectable)	Yellow Fever	Meningococcal	Immune Globulin	Mumps
Pneumococcal Vaccine	Rubella	Tuberculin Test	Tetanus Diphtheria	Plague
Japanese Encephalitis	Rabies	Malaria Drug	Hepatitis B	Cholera

Will children be traveling with you?   Yes   No

If yes, please list their names and date of birth:

____________________________, ____________________________, ____________________________

What is the name, address and phone number of your family physician?______________________________

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