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PATIENT'S NAME (LAST, FIRST, MIDDLE)							HOME PHONE
PATIENT'S HOME ADDRESS			APT. NO.	CITY	STATE	ZIP	BUSINESS PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	AGE	SEX	SPOUSE'S NAME			SPOUSE'S PHONE
PATIENT'S OCCUPATION		PATIENT'S EMPLOYER			PATIENT'S EMPLOYER ADDRESS		
EMERGENCY CONTACT		ADDRESS			PHONE NUMBER	RELATIONSHIP	
<b>INSURANCE:</b> Most insurance plans do not cover travel immunizations, therefore, we do not participate. We will, however, submit one courtesy claim for those covered by Blue Cross/Blue Shield of the National Capital Area only. Medicare ID# _____ Effective Date _____ BCBS NCA ID# _____ Group # _____ Subscriber _____							
Personal Physician:				Referred By:			

### MEDICAL HISTORY

#### ALLERGIES (FOOD, DRUGS, ENVIRONMENTAL FACTORS):

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

#### Do you have any of the following:

- |                           |                              |                             |                            |                              |                             |
|---------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| Psoriasis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart rhythm problems      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other psychiatric disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizure disorder/epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                            |                              |                             |

Are you at risk for immune deficiency? .....  Yes  No

Are you currently taking any medications (including over-the-counter drugs)? .....  Yes  No

If yes, please list: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

#### TRAVEL-RELATED APPOINTMENTS:

IS YOUR TRAVEL FOR:  Business  Pleasure

Destinations: Country(s): \_\_\_\_\_

Length of Travel \_\_\_\_\_ Date of Departure \_\_\_\_\_ Will you be in Rural areas  Yes  No

#### WOMEN ONLY

Are you pregnant or are you considering trying to become pregnant during your stay abroad? .....  Yes  No

Are you breast feeding? .....  Yes  No