TRAVELERS MEDICAL CENTER
PATIENT REGISTRATION

Name: _____ Date of Birth: ____/____/____ Sex: M F
Address: _____ Phone: Home _____
City: _____ State:_____ Zip: _____ Cell _____

Allergies to Antibiotics: Y____ N____ If so, name_____
Other Medicine allergy: Y____ N____ Egg Allergy: Y___ N___
Are you on steroids? Y____ N____ Being treated for any cancer? Y___ N___
Do you have diabetes? Y____ N____ Heart or lung disease? Y___ N___
Do you have a history of a deficiency of the immune system? Y___ N___
Have you ever had an adverse reaction to an immunization? Y___ N___
List the current medications that you are taking: _____
_____
FOR WOMEN: Date of last menstrual period: ____/____/____
Are you pregnant, suspect you are pregnant, or trying to become pregnant? Y___N___

TRAVEL INFORMATION

Date of departure: ____/____/____ Date of return: ____/____/____
Please indicate the countries to which you are traveling in the order you will visit them:

Destination	Length of stay
_____	_____
_____	_____
_____	_____
_____	_____

What is the purpose of travel (circle)?

Vacation Business Study Teaching Volunteer
Field work Missionary Diving Climbing Safari

Travel Plans (circle all that apply)

resort hotels	cruise ships	camping
small hotels	renting a home	staying with a family
rural travel	contact with local citizens	hostels

List the vaccines you have had in the past and the date you received them.

Tetanus	_____	Hepatitis A	_____	Yellow Fever	_____
Polio	_____	Hepatitis B	_____	Influenza	_____
Measles	_____	Typhoid	_____	Pneumonia	_____
Mumps	_____	Cholera	_____	Rabies	_____
Rubella	_____	Meningitis	_____	Japanese Encephalitis	____

Referred by: _____
Name of your physician: _____