IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

CONFIDENTIAL INTERVAL HISTORY FORM

NAME:__________________________________**BIRTHDATE:**______________

⇨ REASON(S) FOR YOUR VISIT TODAY

☐ I am returning for a follow-up visit for: ____

☐ Blood test for: ____

☐ TB (tuberculosis) test

☐ Vaccination for ☐ Immigration ☐ Work Vaccine(s):______________________________
☐ School ☐ Personal Health

☐ Exposed to a contagious disease. Name of disease: __________________________________

⇨ ANY RECENT CHANGES TO YOUR HEALTH STATUS

Since your last visit to AITC:

Any changes with your health history or medical conditions? ☐ No ☐ Yes

Any changes with your medications? ☐ No ☐ Yes

Any new allergies? ☐ No ☐ Yes

Have you had any vaccines given elsewhere (not at AITC)? ☐ No ☐ Yes

IF YOU ANSWERED **YES** TO ANY OF THE ABOVE, PLEASE DESCRIBE:

____

____

⇨ TELL US HOW YOU REACT TO VACCINES

What meal(s) have you eaten so far today? ☐ Breakfast ☐ Lunch ☐ Snack ☐ Nothing

Have you ***ever*** ...

- fainted or felt light-headed from a shot? ☐ No ☐ Yes
- fainted or felt light-headed from having blood taken? ☐ No ☐ Yes
- had any unusual reaction to a vaccine? ☐ No ☐ Yes ➔ Describe: ____________________________

⇨ FEMALES ONLY

Are you breastfeeding now? ☐ No ☐ Yes

When did your last menstrual period start? (Date) __________________ ☐ I do not have menstrual periods

Contraception/Birth control method: ☐ None ☐ Birth Control Pill ☐ Condoms ☐ IUD ☐ Other ____________

Are you pregnant now? ☐ No ☐ Yes ☐ Maybe

➔ If no, is there a reason why you could not possibly be pregnant now (for example "my uterus was removed" or "I don't have sex with men") ____

Are you planning to become pregnant soon? ☐ No ☐ Yes ➔ When? __________________________

⇨ PLEASE SIGN HERE

I certify that the above information is correct to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions that I may have made in completing this form.

____ __________________________

SIGNATURE OF CLIENT (OR PARENT/GUARDIAN) TODAY'S DATE

____

PRINT NAME OF CLIENT (OR PARENT/GUARDIAN)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT of PUBLIC HEALTH

NAME:________________________ **BIRTHDATE:**____________

Please leave these sections BLANK—AITC Staff will complete

HISTORICAL				TODAY'S VISIT							
# doses	Date of Last				Dis	Rec	Dec	Def	Ser #	Site	Lot #
		☐+Dz | Serol ☐+ ☐-	Hep A		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep B		☐	☐	☐	☐			
			Twinrix		☐	☐	☐	☐			
		☐Gardsl ☐Cervarx	HPV	☐Gardsl ☐Cervarx	☐	☐	☐	☐			
			Influenza	☐Inj ☐Pfree ☐FluMist	☐	☐	☐	☐			
		☐JE Vax ☐Ixiaro	JE	☐Ixiaro	☐	☐	☐	☐			
		☐ Menomu ☐ Menact ☐ Menveo	MenACWY	☐ Menomu ☐ Menact ☐ Menveo	☐	☐	☐	☐			
		☐ Bexsero ☐Trumen	MenB	☐ Bexsero	☐	☐	☐	☐			
			MMR		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Measles		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Mumps		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Rubella		☐	☐	☐	☐			
			Pneumovax		☐	☐	☐	☐			
			Prevnar13		☐	☐	☐	☐			
			PPD		☐	☐	☐	☐			
			Polio		☐	☐	☐	☐			
			Rabies	☐Imovax ☐Rabavert	☐	☐	☐	☐			
		☐Td ☐Tdap	Tetanus	☐Adacl ☐Td ☐Boostx	☐	☐	☐	☐			
		☐injectable ☐ oral	Typhoid	☐Typhim ☐Vivovif	☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Varicella		☐	☐	☐	☐			
			Yellow Fever		☐	☐	☐	☐			
			Zostavax		☐	☐	☐	☐			

Hep RISK ASSESSMENT	
Prior Risk Factor(s)	☐HBV ☐HCV ☐Neither ☐Unsure
Prior Testing	☐HBV ☐HCV ☐Neither ☐Unsure
HBV Test Result (if done)	☐Infected ☐Immune ☐Susceptible ☐Unsure
HBV Vax Series Completed ***Before*** Risk Began?	☐No ☐Yes ☐Unsure ☐N/A
HBV Panel Recommended?	☐No ☐Yes
HCV Ab Test Recommended?	☐No ☐Yes

RX	Dis	Rec	Dec	Def	Ordered
Malaria Prophylaxis	☐	☐	☐	☐	☐Malarone ☐Doxycycline ☐Chloroq ☐ Mefloquine
Travelers' Diarrhea	☐	☐	☐	☐	☐Cipro ☐Azithro ☐Rifaximin ☐Tinidazole
Altitude	☐	☐	☐	☐	☐Acetazolamide
Anaphylaxis	☐	☐	☐	☐	☐Epi-Pen
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

BLOOD TESTS	Dis	Rec	Dec	Def	Ordered
Measles IgG	☐	☐	☐	☐	☐
Mumps IgG	☐	☐	☐	☐	☐
Rubella IgG	☐	☐	☐	☐	☐
VZV IgG	☐	☐	☐	☐	☐
HAV Antibody	☐	☐	☐	☐	☐
HBs Antibody	☐	☐	☐	☐	☐
HBs Antigen	☐	☐	☐	☐	☐
HBc Antibody	☐	☐	☐	☐	☐
HCV Antibody	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

COUNSELING	
Food/Water Precautions	☐
Travelers' Diarrhea Management	☐
Insect/Mosquito Precautions	☐
Altitude Precautions	☐
Animal Bite/Rabies Precautions	☐

Additional Comments:

AITC Provider Signature:

Date: