FLOWER MOUND PHARMACY
making your health our business

1001 Cross Timbers Rd. #1170
Flower Mound, TX 75028
Ph: 972-355-4614

Travel Immunization Intake Form

Patient Information

Last Name: First Name: Gender: M / F Date of Birth:

Address:

Phone#: Email:

Primary Physician: Physician Phone#:

Travel Information

Reason for Travel: [ ] Business [ ] Pleasure [ ] Church/Mission [ ] Other:

Destination Information:

Destination	Date of Departure	Date of Return	Area Type (Rural/Urban)

Medical Information

Do you feel sick today? [ ] Yes [ ] No If yes, please describe:

Do you have any chronic conditions? [ ] Yes [ ] No
If yes, please list:

Allergies? Please List:

Please list current medications (including over the counter and supplements):

Medication Name	Strength	Directions
Ex: Asprin	*81 mg*	*Take one by mouth once daily*

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Vaccination Information

Have you been vaccinated in the past 28 days? [ ] Yes [ ] No If yes, please list:

Have you ever received these vaccinations and if so, when?
Ex: [x] Vaccination 01/01/2019

[ ] Hepatitis A
[ ] Hepatitis B
[ ] Meningococcal (meningitis)
[ ] Tetanus (Tdap)
[ ] Tetanus (Td)
[ ] Varicella
[ ] MMR
[ ] Typhoid
[ ] Yellow Fever

Women Only: Are you pregnant or plan to become pregnant? [ ] Yes [ ] No
Are you breastfeeding? [ ] Yes [ ] No

Patient Name (Print): **Date:**

Patient Signature:

How did you hear about Travel Immunization Clinic?
[ ] Referral [ ] Facebook [ ] Website [ ] Other:

FOR OFFICE USE ONLY

Recommendation and Plan:

Consulting Pharmacist: **Consultation Price: $**

Date: