



BELOIT MEMORIAL  
HOSPITAL  
*Occupational Health Centers*

## **Occupational Health Centers**

Thank you for your interest in our travel program. Once you've completed the questionnaire, please return it to us so we may process your request. Once our doctor has analyzed the information, we will contact you with his recommendation(s) for immunizations.

Please be aware that this service is FEE-AT-TIME-OF-SERVICE. We accept credit cards, personal checks, and cash only.

1650 Lee Lane  
Beloit, WI 53511  
(608) 364-4666  
(608) 364-4670 - Fax

## Patient Information

Last Name		First Name		Middle Initial		Company Name		Dept #	
Address: Street		Apt. No.		City		State		Zip	
Home Telephone		Work Telephone		Birth date		Sex		Todays Date	
SS #		Height		Weight		Spouse's Name		Marital Status S M D W	
Person to Contact In Case of Emergency - Relationship - Phone Number								How Did You Hear of Us?	

### **CURRENT TRAVEL ITINERARY IN SEQUENCE:**

Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_

Tourist \_\_\_\_\_ Missionary \_\_\_\_\_

Student \_\_\_\_\_ Studying What \_\_\_\_\_

Work \_\_\_\_\_ Type of Work and Area Will Be Working In: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **EXACT LOCATIONS:**

	Country, Providence or State (Urban or Rural?)	Contact W/Animals	Length of Stay (Days)
1.	_____	Yes/No	_____
2.	_____	Yes/No	_____
3.	_____	Yes/No	_____
4.	_____	Yes/No	_____
5.	_____	Yes/No	_____

Return To:  Beloit Occupational Health  
1650 Lee Lane  
Beloit, WI 53511  
(608) 364-4666  
(608) 364-4670 - fax

Janesville Occupational Health  
1321 Creston Park Drive  
Janesville, WI 53545  
(608) 757-1217  
(608) 755-1790 - fax

Darien Occupational Health  
300 North Walworth  
Darien, WI 53114  
(262) 882-1151  
(262) 296 -1195 - fax

Yes    No

1. Do you understand that you are responsible for an office fee on the first visit, plus the cost of each vaccine. Payment by check, cash, or credit card. We are unable to bill insurance.
2. Do you understand if this form is sent to the doctor and you cancel your trip or decide not to use our service you are charged \$15?
3. Do you have any known allergies? (If so list) \_\_\_\_\_  
\_\_\_\_\_
4. Are allergic to eggs, chicken, chicken feathers, horses, dust pollen, rag weed?
5. Do you have milk intolerance?
6. Are you pregnant, suspect you might be, plan to become pregnant within a year?
7. Are you breastfeeding?
8. Have you had a fever in the past 48 hours?
9. Do you plan to take steroids (oral, cortisone, injectable) in the next 14 days, or have you taken them in the past 14 days?
10. Do you have any known chronic or serious illness?
11. Are you or anyone in your household immunosuppressed (on chemotherapy, receiving radiation, HIV infected)?
12. Do you have kidney disease?
13. Do you have heart disease or high blood pressure?
14. Do you have liver disease (cirrhosis, hepatitis, other)?
15. Do you drink alcohol? (2 or more drinks per week)
16. Do you have a seizure disorder?
17. Do you currently have diarrhea, nausea, vomiting or a history of gastrointestinal disorders? \_\_\_\_\_
18. Do you have psoriasis?
19. Do you have a known allergy to sulfa antibiotics? (i.e. Sulfa, Gantrisin, Septra, Bactrim)

**WHAT CURRENT MEDICATIONS ARE YOU TAKING:**

List Drug/Dose/Frequency

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

**HAVE YOU EVER BEEN IMMUNIZED OR HAD THE FOLLOWING DISEASES?**

	Date of Injection	Date of Disease	Update Year
Polio – Oral/Shots			
Measles (7-10 Days)			
Mumps			
Rubella (3 Days)			
Born After 1957 – Had MMR Booster Between Ages 18-35			
Tetanus			
Diphtheria			
Chicken Pox			
Cholera			
Typhoid			
Yellow Fever			
Gammaglobulin			
Hepatitis A			
Hepatitis B			
Flu Vaccine			
Japanese Encephalitis			
Lyme Disease			
Rotavirus			
Rabies			
Meningococcal			

Once you have completed the questionnaire, please click the submit button so we can process it.