PASSPORT HEALTH-TRIANGLE PATIENT INFORMATION/CONSENT

NAME:____ Date_______________
Last First Middle Initial

ADDRESS:____
Street City State Zip

HOME PHONE_______________ WORK PHONE______________ E-MAIL:_________________

I authorize Passport Health to contact me at the above address and phone numbers? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?____

BIRTHDATE:_________________________ AGE:_________ SEX: ☐ MALE ☐ FEMALE

EMPLOYER:__________________________OCCUPATION:___________________________

EMERGENCY CONTACT:___________________RELATIONSHIP__________PHONE__________

PRIMARY CARE PHYSICIAN:____________________________PHONE:__________________

ADDRESS/LOCATION:____

Do you want us to send your primary care physician a copy of your immunization record? ☐yes ☐no

May we contact you via e-mail regarding your travel experience or possible research? ☐yes ☐no

ALLERGIES Please circle if you have any known allergies to the following substances: **NONE, chicken eggs feathers, yeast, gelatin, mercury, thimerosal, sulfa, aluminum, aluminum hydroxide, quinine, formaldehyde, latex, insect/bee stings**

Any other known allergies? Please explain____

MEDICATIONS **NONE** List current medications (including oral contraceptives or anticoagulants):_____________
____

MEDICAL HISTORY

1) Are you pregnant now or possibly pregnant? YES NO Are you planning pregnancy in the next three months? YES NO
2) Have you had an allergic reaction to a vaccination in the past? YES NO EXPLAIN______________
3) Do you have any chronic medical or mental illness? YES NO EXPLAIN______________
4) Do you have high blood pressure? YES NO EXPLAIN______________
5) Are you taking any steroid medications, cortisone or prednisone? YES NO EXPLAIN______________
6) Are you receiving radiation or any other treatments? YES NO EXPLAIN______________
7) Do you have any skin conditions such as dermatitis or eczema? YES NO EXPLAIN______________
8) Have you ever had a seizure, convulsion or epilepsy? YES NO EXPLAIN______________
9) Are you prone to motion sickness? YES NO EXPLAIN______________
10) Are you traveling against the advice of a physician? YES NO EXPLAIN______________
11) Any other medical conditions or acute problems? YES NO EXPLAIN______________

IMMUNIZATION HISTORY

Please see reverse side to complete shot record. Reviewed by RN_____________________

TRAVEL INFORMATION

Where are you going? (List individual countries in sequence of visit)

____

Leaving:_____________________ Returning:___________________ Length of stay:____________

Purpose of visit (pleasure/business):_______________Planned activities/accommodations_______________

The above information is accurate to the best of my knowledge. I understand that Passport Health will not file insurance and I am responsible for all fees associated with this visit. Passport Health is not a Medicare provider. **Payment is due at the time of service**, **There is a $45 fee for all returned checks**. I understand I will receive documentation of all vaccines received and am responsible for keeping the record in a safe place and up-to-date. Passport Health keeps active records on file. Inactive records are kept on file for 3 years.

Traveler/Parent/Guardian Signature:____Date_______________

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PASSPORT HEALTH-RTP PATIENT INFORMATION/CONSENT
IMMUNIZATION REVIEW

NAME:_________________________________ **DATE:**________________

Please CHECK all that apply and DATE accordingly
Excluding Childhood Immunizations

☐ **NONE**

IMMUNIATIONS	MONTH/YEAR RECEIVED
Hepatitis A (series of 2)	year completed series_________
Hepatitis B (series of 3)	year completed series_________
Immune Globulin	
Influenza	
Flu Mist	
Japanese Enc. (series of 3)	year completed series_________
MMR	
Menactra (Meningitis)	
Menomune (Meningitis)	
Polio	
PPD	
Rabies (series of 3)	year completed series_________
Tetanus Diphtheria	
T/d & Pertussis	
Typhoid (Oral or Injection?)	
Twinrix (Hep AB, series of 3)	year completed series_________
Varicella (Chicken Pox)	year completed series_________
Yellow Fever	
OTHER	

COMMENTS:

Office Use Only
Reviewed by RN______________________________________ **Date:**___________________

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