



PASSPORT HEALTH
First Class Medical Care For Travel Anywhere

PASSPORT HEALTH PATIENT INFORMATION/CONSENT
Part I

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

DATE TODAY: _____ BIRTHDATE: ____/____/____ AGE: _____ SEX: Male Female
Month Date Year

HOME PHONE#: _____ CELL PHONE#: _____ LAST 4 OF SS# _____

HAVE YOU BEEN HERE BEFORE? Yes No WHEN? _____

EMPLOYER: _____ WORK PHONE: _____

REGISTER TO RECEIVE OUR FREE E-ZINE, HEALTH ALERTS, TRAVEL NEWS & HOT TRAVEL DESTINATION INFORMATION? yes no **EMAIL:** _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS/LOCATION: _____

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

Where are you going? (Please List Countries in Order)	Approximate Length of Stay in Each Country
_____	_____
_____	_____
_____	_____

Departure Date _____ Return Date _____

Chronic physical or mental illnesses: _____

Do you have eczema or other chronic dermatitis? yes no If yes, type _____

Previous History of tendonitis/tendon rupture yes no

No known allergies to medications. Medication allergy to: _____

List all recent vaccines you have had and dates if known including oral or nasal mist: _____

Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings? _____

Motion Sickness? yes no If yes, what have you used in the past? _____

Do you have high blood pressure? yes no If yes, are you on medication? _____

Current medications (including oral contraceptives or anticoagulants): _____

Are you receiving steroid medications such as cortisone or prednisone? yes no If yes, type _____

Are you receiving radiation or other treatments? yes no If yes, type _____

Are you pregnant now or is there a possibility that you might be pregnant? yes no If yes, months _____

Have you had an allergic reaction to an immunization in the past? yes no If yes, what? _____

The above information is accurate to my best recollection. I understand that insurance may not cover travel immunization services 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 by check, cash or credit card. 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: _____

PLEASE CONTINUE TO THE BACK OF THIS PAGE



PASSPORT HEALTH PATIENT INFORMATION/CONSENT
Part II

To Allow Us to Serve you Better, Please Provide The Information Below:

How Did You Hear About Us

- Return Client Friend
- Family Member
- Primary Care Physician
- Passport Health Client
- Pharmacist
- Travel Agent
- Company Travel Manager
- School/College Nurse
- CDC Site
- Health Department
- TV/Cable Advertisement _____
- Direct Mail _____
- Internet Ad where? _____
- Internet Search _____
- Other Internet Site _____
- Radio _____
- Other _____

Channel/Network _____
 Promotional Code _____
 Website _____
 Search Engine _____
 Website _____
 Station _____
 Please Specify _____

SO THAT WE MAY SEND A THANK YOU, PLEASE TELL US MORE ABOUT THE PERSON WHO REFERED YOU

EMAIL _____
 Salutation First Name Last Name

 Street City State Zip PHONE _____

FOR OFFICE USE ONLY

Would you be interested in receiving additional information regarding research studies? yesno

Purpose of visit Business Leisure Mission Study Abroad Visiting Friends/Family Adoption Other

Are you Traveling Alone? In a Group? With Your Company? With Your School?

Please rate your initial experience (on a scale of 1 to 5 with 5 being the best)

Phone Professionalism: _____ Appointment Availability: _____ Access to Locations: _____

COMMENTS: _____

Thank you for your Visit to Passport Health. Your answers are strictly confidential and they will assist us in our efforts to serve you better.