

PASSPORT HEALTH PATIENT INFORMATION/CONSENT

Please Print

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

BIRTHDATE: _____ AGE: _____ SEX: FEMALE MALE HOME TEL: _____

E-MAIL: _____ CELL TEL: _____

EMERGENCY CONTACT: _____
Name Relationship Phone

EMPLOYER: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____
Street City State Zip Code

OCCUPATION: _____

Referred By: (please check & complete all that apply) Web Search Source: _____
 Physician Friend Advertising: _____

Corporate Travel Coordinator Name: _____ Phone: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS/LOCATION: _____

As a courtesy, do you want us to send your primary care physician a copy of your immunization record? yes no

May we contact you after your trip regarding your health for possible research? yes no

Would you like to receive information regarding health alerts, outbreaks & vital travel information? yes no

Places to be visited: (Please Note any possible SIDE TRIPS that you might be interested in taking):

Country	Town	Rural Area		Dates: (including year)	
		Yes	No	From	To

Purpose of travel: _____

If you have motion sickness, what have you used in the past? _____

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 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: _____ **DATE:** _____

PASSPORT HEALTH MEDICAL QUESTIONNAIRE

Current medications (include oral contraceptives, mood elevators, ANTIBIOTICS, Antimicrobials, blood pressure):

Are you feeling sick today? _____ If "yes", rate your sickness: MILD MODERATE SEVERE
 Symptoms: _____ Do you have a fever? _____
 Have you ever had a seizure, convulsion or epilepsy? _____
 Do you have eczema, psoriasis, or other chronic dermatitis () yes () no If yes, type _____
 Do you have chronic mental illness, panic attacks, depression, mood swings, or other psychiatric problems? _____
 History of Guillain-Barre Syndrome? _____ History of jaundice or hepatitis? _____
 Have you ever fainted from a shot? _____ Do you have cardiac arrhythmias or irregularity? _____
 Have you had the Chicken Pox disease? _____ Do you have a problem with strange dreams and/or nightmares? _____
 Do you have an existing medical condition (examples: diabetes, heart disease, renal (kidney) insufficiency, hepatic (liver) insufficiency, pulmonary (lung) chronic pneumonia/bronchitis/COPD, retinopathy (eye), or others? _____

Please check – "yes, no, or I don't know" to the following questions:	Yes	No	I don't know
Do you have allergies: medications, food, or any vaccine (e.g.. eggs, yeast, gelatin, sulfa, streptomycin, neomycin, polymixin B, latex, quinine, insect/bee stings, phenol, thimerosal or mercury, aluminum, formalin, feathers)? If yes, allergy to: _____			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have cancer, leukemia, AIDS, any other immune system problem or G6PD deficiency?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments (Radiation Therapy)?			
During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
Have you received any vaccinations in the past 4 weeks?			
For women: Are you pregnant? If yes, number of months pregnant: _____ <div style="text-align: right; margin-right: 50px;">**** Pregnancy likely within 3 months? Are you currently breastfeeding?</div>			
Are you traveling against the recommendation of a physician? If yes, what is the condition?			
Have you eaten today?			

The above information is accurate to my best recollection. Inactive records are kept on file for 3 years.

Traveler/Parent/Guardian Signature: _____ **Date:** _____

For Office Use Only:

<u>Last doses:</u>	
Tetanus/Diphtheria: _____ Pertussis: _____ Polio: _____ Typhoid: _____ Injection/Pills: _____	
Started Series? _____	Varicella: _____ # doses: _____
Hep A? _____ # doses: _____	Twinrix: _____ # doses: _____
Hep B? _____ # doses: _____	
FLU shot: _____ MMR _____	* Will Need (2) doses: if had MMR doses from 6-11 months of age, OR had vaccine before 1968 with an <u>unknown</u> type of vaccine.
Pneumonia shot: _____	Note: If born before 1957 and there is reason to believe that you might be susceptible, may give one (1) MMR.
Meningococcal: _____	
Thymectomy: (yes/no) _____	
Yellow Fever Shot: _____	

***Thank you for your visit to Passport Health. Your answers are strictly confidential & they will assist us in our effort to serve you better.