Passport Health® Patient Registration

Patient's Name: (Last, First, Middle initial)		Date of Birth:
Address: City: State: Zip:		Home Phone Number:
Sex: ◉ Male ○ Female	Marital Status: ◉ Single ○ Married ○ Widowed ○ Separated ○ Divorced	Work Phone Number:
Employer Name:	Employer Address:	Occupation:
Person to call in case of Emergency:	Relationship:	Home Phone Number: Work Phone Number:

Medical History

What is the name, address, and phone number of your family physician or primary care provider:

Current Medications: (please list, including oral contraceptives, or steroids e.g. Cortisone or prednisone.)

_____
_____
_____

Please list ***ANY*** medication allergies and your reactions:

_____
_____
_____

Are there ***ANY*** other health concerns or issues that we should know about. (Anxiety attacks, fear of needles, claustrophobia, etc.)

_____
_____
_____

Do you have any allergies to any of the following items? (Mark all that apply)

I have no known allergies

☐ Eggs	☐ Medicine	☐ Antibiotics (esp. Neomycin)	☐ Mercury (thimerosal)
☐ Feathers	☐ Sunlight	☐ Grass or Mold	☐ Formaldehyde
☐ Vaccines	☐ Quinine	☐ Yeast	☐ Insect/ Bee Stings

Are you traveling against medical advice (AMA)?	○ YES	○ NO
Are you being treated for leukemia, lymphoma, cancer, or any other malignant disease?	○ YES	○ NO
Do you have a history of deficiency of the immune system?	○ YES	○ NO
Do you have a history of anemia or any other blood disorder?	○ YES	○ NO
Do you have a history of high blood pressure?	○ YES	○ NO
Do you have a history of motion sickness?	○ YES	○ NO
Do you have eczema or other chronic dermatitis?	○ YES	○ NO
If female, are you pregnant, suspect that you may be pregnant, or are trying to become pregnant?	○ YES	○ NO
If yes, Date of LMP, or months pregnant?_____		
Do you have ***ANY OTHER medical conditions or history*** we should know about?	○ YES	○ NO
If yes, please list:_____		

Please complete the back

Medical History (continued)

Please mark yes or no: Have you:

Had a Tuberculin test or PPD in the past 2 years?	YES	NO
Ever had any reaction to an immunization?	YES	NO
Ever traveled internationally? (other than Canada)	YES	NO
If yes, did you get ill?	YES	NO

What were your symptoms? ☐Nausea ☐Vomiting ☐Diarrhea ☐Fever ☐Infection

Travel Information

Please indicate, **in the order you will visit**, the countries you are traveling to: ***** if more than 3 destinations please bring a COMPLETE list*****

Date of Departure	Destination (City, Country)	Date of return or transfer	Length of stay
First Destination			

Please mark all that apply to your travel plans:
☐Major Resort Hotels ☐Cruise Ships ☐Camping ☐Rural Travel at any time
☐Staying with Family ☐Small Hotels ☐Safari ☐Outdoor activities
☐Rented Foreign Home ☐Youth Hostel ☐Other

What is the purpose of your travel? (mark all that apply)
☐Business ☐Student ☐Vacation ☐Missionary ☐Teacher ☐Volunteer Agency
☐Field Work ☐Mt.Climbing ☐Diving ☐Adoption ☐Other ☐

Second Destination			

Please mark all that apply to your travel plans:
☐Major Resort Hotels ☐Cruise Ships ☐Camping ☐Rural Travel at any time
☐Staying with Family ☐Small Hotels ☐Safari ☐Outdoor activities
☐Rented Foreign Home ☐Youth Hostel ☐Other

What is the purpose of your travel? (mark all that apply)
☐Business ☐Student ☐Vacation ☐Missionary ☐Teacher ☐Volunteer Agency
☐Field Work ☐Mt.Climbing ☐Diving ☐Adoption ☐Other ☐

Third Destination			

Please mark all that apply to your travel plans:
☐Major Resort Hotels ☐Cruise Ships ☐Camping ☐Rural Travel at any time
☐Staying with Family ☐Small Hotels ☐Safari ☐Outdoor activities
☐Rented Foreign Home ☐Youth Hostel ☐Other

What is the purpose of your travel? (mark all that apply)
☐Business ☐Student ☐Vacation ☐Missionary ☐Teacher ☐Volunteer Agency
☐Field Work ☐Mt.Climbing ☐Diving ☐Adoption ☐Other ☐

OPTIONAL SURVEY QUESTIONS: Answering the following questions will help us with our research.

How did you hear about our service?
☐Family/Friend ☐Doctor's Office ☐Work ☐Other_____ (specify)
☐Travel Agency ☐Internet

Last grade completed:
☐Graduate School or Higher ☐College Graduate ☐Partial College ☐High School Graduate
☐Partial High School ☐Junior High School ☐Less than 7 years of school ☐Preschool

Occupation:
☐High executive, proprietors of large concerns
☐Business manager, proprietors of medium sized businesses
☐Professional (Physician, Nurse, Lawyer, Educator, etc.)
☐Administrative personnel, small independent businesses
☐Machine operator and semi-skilled employee
☐Clerical and sales workers, technician
☐Skilled manual employee
☐Unskilled employee
☐Military service
☐Retired
☐Homemaker
☐Student
☐Other: _____

The above information is true and accurate to the best of my knowledge. -I give my consent, voluntarily and of my own free will, to the medical staff to provide medical recommendations and care. -I am aware of the URMC / Strong Health Notice of Privacy Practices and know that I can receive a copy of it at the time of my visit or on the University website. -I understand that the risks and benefits of any vaccine or medication will be explained to me in written and verbal form, and I will have all my questions answered prior to receiving any vaccinations. -I waive any claims against the University of Rochester, its officers, directors and employees whether caused by my negligence or the negligence of others. -I also agree to provide my Primary Care Provider with a copy of my immunization(s). -I understand that insurance may not cover for travel health services and that payment is due at the time of services by cash, check, Visa or MasterCard or Discover.

_____ _____

Signature of Patient, Parent or Guardian Date