



Patient's Name: (Last, First, Middle initial)		Date of Birth:	
Address:		City:	State: Zip:
Home Phone Number:			
Last 4 digits of SSN: xxx-xx- _____	Sex: <input type="radio"/> Male <input type="radio"/> Female	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> 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

- | | | | |
|--------------------------------|--------------------------------|---|--|
| <input type="radio"/> Eggs | <input type="radio"/> Medicine | <input type="radio"/> Antibiotics (esp. Neomycin) | <input type="radio"/> Mercury (thimerosal) |
| <input type="radio"/> Feathers | <input type="radio"/> Sunlight | <input type="radio"/> Grass or Mold | <input type="radio"/> Formaldehyde |
| <input type="radio"/> Vaccines | <input type="radio"/> Quinine | <input type="radio"/> Yeast | <input type="radio"/> Insect/ Bee Stings |

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

Medical History (continued)

Please mark yes or no: Have you:

- | | | |
|--|---------------------------|--------------------------|
| Had a Tuberculin test or PPD in the past 2 years? | YES <input type="radio"/> | NO <input type="radio"/> |
| Ever had any reaction to an immunization? | YES <input type="radio"/> | NO <input type="radio"/> |
| Ever traveled internationally? (other than Canada) | YES <input type="radio"/> | NO <input type="radio"/> |
| If yes, did you get ill? | YES <input type="radio"/> | NO <input type="radio"/> |
- 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			
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- 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			
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- 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?

- Print ad (newspaper/magazine) Radio TV Family/Friend Doctor's Office Work Other _____ (specify)
 Travel Agency Corporate Travel Manager (specify)

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:

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

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 URM / 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