



Today's Date: _____

REGISTRATION FORM

PERSONAL DATA (PLEASE PRINT CLEARLY)				
NAME:	Last Name	First Name	AGE	DOB: _____
	Mi			SEX: M F
HOME ADDRESS:	Street		City	State Zip
PHONE #	Home	Office	Cell	E-MAIL
EMPLOYER:	OCCUPATION:			
EMERGENCY CONTACT:	Name	Relationship	Phone Number	

PRIMARY CARE PHYSICIAN INFORMATION

NAME:	PHONE:
ADDRESS:	
As a courtesy, do you want us to send your physician a copy of your immunization record?	YES <input type="checkbox"/> NO <input type="checkbox"/>

TRAVEL INFORMATION

Please list the countries you are traveling to, in the order you will visit them:

Date of Departure	Destination (City, Country)	Date of Return or Transfer	Length of Stay

Please mark all that apply to your travel plans:				
<input type="checkbox"/> TOURIST	<input type="checkbox"/> BUSINESS	<input type="checkbox"/> STUDENT	<input type="checkbox"/> TEACHER	<input type="checkbox"/> FIELD WORK
<input type="checkbox"/> ADOPTION	<input type="checkbox"/> MISSIONARY	<input type="checkbox"/> ADOPTION	<input type="checkbox"/> CRUISE SHIP	<input type="checkbox"/> YOUTH HOSTEL
<input type="checkbox"/> SMALL HOTELS	<input type="checkbox"/> MAJOR RESORT	<input type="checkbox"/> STAYING WITH FAMILY	<input type="checkbox"/> RENTED HOME	<input type="checkbox"/> CAMPING
<input type="checkbox"/> SAFARI	<input type="checkbox"/> CLIMBING	<input type="checkbox"/> DIVING	<input type="checkbox"/> RURAL TRAVEL AT ANY TIME	
Are you traveling: <input type="checkbox"/> With your Company? <input type="checkbox"/> In a group? <input type="checkbox"/> With your school? How many in your group? _____				
Who arranged your trip: name _____ phone _____ e-mail _____				

How did you hear about Passport Health?				
<input type="checkbox"/> Return Client	<input type="checkbox"/> School/College Nurse	<input type="checkbox"/> Physician	<input type="checkbox"/> Direct Mail	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> CDC Website	<input type="checkbox"/> Passport Health Website	<input type="checkbox"/> Travel Agent	<input type="checkbox"/> Employer	<input type="checkbox"/> Friend/Relative
Other _____				
Do you have any health concerns regarding your travel destination?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you traveled internationally in the previous six months?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Would you like to receive information regarding travel health alerts, disease outbreaks, & vital travel information?			YES <input type="checkbox"/>	NO <input type="checkbox"/>

Please complete the back page

MEDICAL HISTORY

Please check yes or no		Please check yes or no	
Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to bee stings?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have high blood pressure or take high blood pressure medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes? If yes, do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have tuberculosis, or tested positive for tuberculosis?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have lung disease, asthma, or chronic bronchitis/shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of depression or psychiatric disorders?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently experiencing any respiratory infections or other acute illness or infections?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an active nerve disorder? Do you have a history of Guillian-Barre Syndrome?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any skin diseases or psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Are you prone to motion sickness?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience nightmares or insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to eggs, yeast, or any other foods?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you, any person you live with, or any person in your care have AIDS, or is HIV Positive, or have cancer, leukemia, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	Do you, any person you live with, or any person in your care take any cortisone, prednisone steroids, chemotherapy, or radiation therapy?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have stomach/bowel conditions such as frequent diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fainted from an injection or from having your blood drawn?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever traveled internationally (other than Canada)? If yes, did you get ill? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were your symptoms? <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Infection	<input type="checkbox"/>	<input type="checkbox"/>	During the past three (3) months have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?
	Yes	No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to any drug, medication, vaccine or vaccine component, thimerosal, protamine sulfate, or mercury (a preservative)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are you allergic to? _____	Are you currently taking any medications including oral contraceptives and blood pressure medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list _____ _____		
Are there ANY other health concerns or issues that we should know about? (Anxiety attacks, fear of needles, claustrophobia, etc.) _____ _____	Prior Immunization Dates: Tetanus/Diphtheria _____ Polio _____ Yellow Fever _____ Meningitis _____ Influenza _____ Varicella _____ Pneumonia _____ MMR _____ PPD _____ Typhoid _____ Injection/Pills _____ Hep A _____ # Doses _____ Hep B _____ # Doses _____ Twinrix _____ # Doses _____ Rabies _____ # Doses _____ Japanese Encephalitis _____ # Doses _____ Antimalarial? _____ (name) <input type="checkbox"/> Copy of immunization record provided to Passport Health nurse		
QUESTIONS FOR WOMEN Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you plan to become pregnant within the next three months <input type="checkbox"/> Yes <input type="checkbox"/> No Are you breastfeeding (nursing) now? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have problems with vaginitis? <input type="checkbox"/> Yes <input type="checkbox"/> No			

The above information is true and accurate to the best of my knowledge. Passport Health is not a Medicare provider, does not accept insurance for payment, and does no insurance billing or filing of forms. Payment is due at time of service by cash, check, or credit card. I understand that insurance may not cover these services if I submit receipts for reimbursement. I understand I will receive a Vaccine Information Statement (VIS), and documentation on all vaccines received. I have had a chance to ask questions. I understand & accept the risks and benefits of all vaccines I will receive, and request they be provided to me. I understand declining recommended vaccines and meds may result in acquiring these diseases. I am responsible for keeping my records up to date and in a safe place. Passport Health keeps active records on file. Inactive records are kept on file for 3 years.

TRAVELER/PATIENTSIGNATURE _____ DATE _____
 (under 18 years of age must have Parent/Guardian signature)