



Today's Date: _____

Travel Patient Registration Form

NAME: _____ DOB: _____ AGE: _____ SEX: M F
Last First MI

HOME ADDRESS: _____
Street City State Zip

PHONE#: _____
Home Office Cell

E-MAIL: _____
 (Email Address is only used for booster reminders)

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____
Name Relationship Phone #

Primary Care Physician Information

NAME: _____ PHONE: _____

ADDRESS: _____

Do you want us to send your physician a copy of your immunization record? **If yes please fill out and check**

YES _____ NO _____

Travel Information

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

Date of Departure	Destination (City, Country)	Date of return/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"/> MISSIONARY | <input type="checkbox"/> ADOPTION | <input type="checkbox"/> CRUISE SHIP | <input type="checkbox"/> FIELD WORK |
| <input type="checkbox"/> LARGE HOTEL | <input type="checkbox"/> SMALL HOTEL | <input type="checkbox"/> RENTED HOME | <input type="checkbox"/> CAMPING |
| <input type="checkbox"/> STAYING @ FAMILY | <input type="checkbox"/> SAFARI | <input type="checkbox"/> CLIMBING | <input type="checkbox"/> DIVING |
| <input type="checkbox"/> TREKKING | <input type="checkbox"/> RURAL TRAVEL | <input type="checkbox"/> RELOCATION | <input type="checkbox"/> RELIEF WORK |

HOW DID YOU HEAR ABOUT PASSPORT HEALTH?

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> GOOGLE | <input type="checkbox"/> SCHOOL/COLLEGE NURSE
Name: _____ | <input type="checkbox"/> RETURN CLIENT |
| <input type="checkbox"/> INTERNET | <input type="checkbox"/> PHYSICIAN
Name: _____ | <input type="checkbox"/> FRIEND/RELATIVE |
| <input type="checkbox"/> CDC | <input type="checkbox"/> EMPLOYER | <input type="checkbox"/> OTHER: _____ |

Medical History

Do you have heart problems?	Yes	No	Are you allergic to bee stings?	Yes	No
Do you have a cardiac arrhythmia or irregularity?	Yes	No	Do you have diabetes? If, yes do you take insulin? Yes No	Yes	No
Do you have high blood pressure or take high blood pressure medication?	Yes	No			
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	Yes	No	Do you have tuberculosis, or tested positive for Tuberculosis?	Yes	No
Are you currently experiencing any respiratory infections or other acute illnesses or infections?	Yes	No	Do you have a history of depression or psychiatric disorders?	Yes	No
Do you have any skin diseases or psoriasis?	Yes	No	Are you prone to motion sickness?	Yes	No
Do you experience nightmares or insomnia?	Yes	No	Are you allergic to eggs, yeast or any other foods?	Yes	No
Do you, or any person that you live with, or any person in your care have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No	Do you take any cortisone, prednisone steroids, chemotherapy, or radiation therapy?	Yes	No
Do you have any stomach,/bowel conditions such as irritable bowel syndrome, colitis, Crohn's disease or frequent diarrhea?	Yes	No	Have you ever fainted from an injection or from having your blood drawn?	Yes	No
Have you ever traveled internationally (other than Canada)? If yes, did you get ill? Yes No If yes, what were your symptoms? Nausea Vomiting Diarrhea Fever Infection	Yes	No	During the last three months, have you been given a medicine called immune globulin?	Yes	No
			Do you have problems with your thymus gland, or have you had a thymectomy?	Yes	No
			Do you have kidney problems or renal insufficiency?	Yes	No
Are you allergic to any drug, medication, vaccine or vaccine component, thimerosal, or mercury? If yes, to what are you allergic?	Yes	No	Are you currently taking any medications? If yes, Please list them:	Yes	No
Have you ever been diagnosed with Hepatitis? If yes, which Hepatitis did you have?	Yes	No			
			Do you have a chronic disease?	Yes	No

Prior Immunization History/Dates (If adult, other than childhood)

Tetanus/Diphtheria _____	Polio _____	Yellow Fever _____
Hepatitis A _____ # of doses _____	Hepatitis B _____ #of doses _____	Twinrix _____ #of doses _____
Rabies _____ # of doses _____	Japanese Encephalitis _____ # of doses _____	Influenza _____
Typhoid _____ Injection _____ Pills _____	Meningitis _____	Pneumonia _____
Varicella (chicken pox) _____	MMR _____	TB test _____
Have you previously taken anti-malaria pills? Yes No If yes, which medication did you take? _____		
Did you have any side effects with the medication? Yes No If yes, what side effects did you experience? _____		

Questions for Women

Are you pregnant?	Yes	No
Do you plan to become pregnant within the next 3 months?	Yes	No
Are you breastfeeding (nursing) now?	Yes	No
Do you have problems with vaginitis?	Yes	No

The above information is true and accurate to the best of my knowledge. I understand that insurance may not cover these services, and that I am responsible for payment of all fees at the time of service. Passport Health is not a Medicare provider and does no insurance billing or filing of forms. Payment is due by cash, check or credit card. I understand that I will receive official documentation of all vaccines that I received. Passport Health keeps active records on file for 3 years.

Traveler/Parent/Guardian Signature _____ Date _____

(Under 18 years of age must have parent/guardian signature)

Travel Nurse Specialist Signature _____ Date _____