



PASSPORT HEALTH PATIENT INFORMATION/CONSENT

NAME: _____
Last First Middle Initial NICKNAME

ADDRESS: _____
Street City State Zip

DATE TODAY: _____ BIRTHDATE: ____/____/____ AGE: _____ SEX: Male Female
Month Day Year

HOME PHONE: _____ CELL: _____ EMAIL: _____

EMERGENCY CONTACT/RELATIONSHIP: _____ PHONE: _____

HAVE YOU BEEN HERE BEFORE? Yes No WHEN? _____

EMPLOYER: _____

ADDRESS: _____ WORK PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____
(First & Last Name)

ADDRESS: _____

Do you want us to send your primary care physician a copy of your immunization record? yes (must have complete address) no

PHARMACY NAME: _____

CITY/STATE: _____ PHONE: _____

Are you traveling? Yes No (If no, indicate vaccine: _____)

Purpose of visit: Business Leisure Mission Study Abroad Adoption Other _____

Please List Countries in Order Please List Cities/Towns Approximate Length of Stay

Departure Date: _____ Return Date: _____

Do you have eczema or other chronic dermatitis? yes no If yes, type _____

No known allergies to medications. Medication allergy to: _____

Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings? _____

Do you have any history of Guillain-Barré syndrome or paralysis? yes no If yes, type _____

Motion Sickness? yes no If yes, what have you used in the past? _____

MEDICAL HISTORY - Check below if you have or had any of the following:

- Asthma Epilepsy High Blood Pressure Mental Health Issues Tuberculosis
- Cancer Heart Disease HIV Migraine Headaches NONE
- Diabetes Hepatitis Kidney Disease Rheumatoid Arthritis OTHER: _____

Current Medications: _____

PREVIOUS IMMUNIZATIONS: Please indicate (Month/Year) you received your last immunization for:

| | | | |
|-------------|-------------------------|-----------|--------------------|
| Chicken Pox | Twinrix | Pneumonia | Tetanus/Diphtheria |
| Flu | Japanese Encephalitis | Polio | Tdap |
| Hepatitis A | Measles, Mumps, Rubella | PPD | Typhoid |
| Hepatitis B | Meningitis | Rabies | Yellow Fever |

Have you ever taken malaria pills? yes no If yes, did you have any side effects? _____

Are you receiving steroid medications such as cortisone or prednisone? yes no If yes, type _____

Are you receiving radiation or other treatments? yes no If yes, type _____

Are you pregnant now or is there a possibility that you might be pregnant? yes no If yes, months _____

Have you had an allergic reaction to an immunization in the past? yes no If yes, what? _____

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 check, 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: _____

PLEASE CONTINUE TO THE BACK OF THIS PAGE

