



**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**



## PASSPORT HEALTH PATIENT INFORMATION/CONSENT Part II

**To Allow Us to Serve you Better, Please Provide The Information Below:**

**How Did You Hear About Us:**

- |   |   |
|---|---|
| <input type="checkbox"/> Return Client<br><input type="checkbox"/> Primary Care Physician<br><input type="checkbox"/> Passport Health Client<br><input type="checkbox"/> Pharmacist<br><input type="checkbox"/> Travel Agent<br><input type="checkbox"/> Company Travel Manager<br><input type="checkbox"/> School/College Nurse<br><input type="checkbox"/> CDC Site<br><input type="checkbox"/> Health Department<br><input type="checkbox"/> Radio _____<br><div style="text-align: center; margin-left: 100px;">Station</div> | <input type="checkbox"/> TV/Cable Advertisement _____<br><div style="text-align: center; margin-left: 100px;">Channel/Network</div> <input type="checkbox"/> Direct Mail _____<br><div style="text-align: center; margin-left: 100px;">Promotional Code</div> <input type="checkbox"/> Internet Ad where? _____<br><div style="text-align: center; margin-left: 100px;">Website</div> <input type="checkbox"/> Internet Search _____<br><div style="text-align: center; margin-left: 100px;">Search Engine</div> <input type="checkbox"/> Other Internet Site _____<br><div style="text-align: center; margin-left: 100px;">Website</div> <input type="checkbox"/> Other _____<br><div style="text-align: center; margin-left: 100px;">Please Specify</div> |
|---|---|

**SO THAT WE MAY SEND A THANK YOU, PLEASE TELL US MORE ABOUT THE PERSON WHO REFERED YOU**

Salutation	First Name	Last Name	EMAIL _____
Street	City	State	Zip _____ PHONE _____

Would you be interested in receiving additional information regarding research studies?  yes  no

Purpose of visit:  Business  Leisure  Mission  Study Abroad  Adoption  Other

Are you Traveling  Alone?  In a Group?  With Your Company?  With Your School?

**Please rate your initial experience** (on a scale of 1 to 5 with 5 being the best)

Phone Professionalism: \_\_\_\_\_ Appointment Availability: \_\_\_\_\_ Access to Locations: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your Visit to Passport Health. Your answers are strictly confidential and they will assist us in our efforts to serve you better.