

NAME _____ LAST _____ FIRST _____ MIDDLE INITIAL _____

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"/> Yes <input type="checkbox"/> No	Are you allergic to bee stings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have high blood pressure or take high blood pressure medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to eggs, yeast, or any other foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy (X-ray therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have lung disease, asthma, chronic bronchitis, or shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a stomach or bowel condition, such as bowel irritability, frequent diarrhea or constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any skin condition such as psoriasis, eczema or shingles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever fainted from an injection or from having your blood drawn?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience nightmares or insomnia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of depression or psychiatric disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	During the past three (3) months have you received a transfusion of blood or plasma, or been given medicine called immune globulin or Rho-gam?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have Diabetes? If yes, do you take insulin? Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you received any vaccinations in the past 4 weeks? If yes, please specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have tuberculosis? Have you ever tested positive for tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you prone to motion sickness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an active nerve condition? Do you have a history of Guillian-Barre Syndrome or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to any drug, medication, vaccine, or vaccine component, such as penicillin, thimerosal, formalin, sorbitol, albumin, animal serum? <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 _____	

****IMPORTANT: PREVIOUS IMMUNIZATIONS: Please indicate "c" for childhood series completed OR year vaccine received**

Chicken Pox	Immune Globulin	Polio	Yellow Fever
Flu	Japanese Encephalitis	Pneumonia	
Hepatitis A	Measles, Mumps, Rubella	Rabies	
Hepatitis B	Meningitis	Tetanus/Diphtheria/Pertussis	
Have you ever taken malaria pills? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you have any side-effects?			

QUESTIONS FOR WOMEN

Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you breastfeeding (nursing) now?	<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	Do you have problems with vaginitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IMMUNIZATION RECORD

Did you bring your immunization record with you? If not, we will provide one for you. Always bring this record with you for clinic visits. Make sure all your immunizations are recorded.

The above information is accurate to my best recollection. I understand Passport Health is not a Medicare provider and does no insurance billing or filing of claims. I am responsible for all fees due at time of service.

TRAVELER/PATIENT SIGNATURE _____ DATE _____

REMEMBER – PLEASE EAT BEFORE YOUR APPOINTMENT. If you have not eaten recently, let the nurse know.

**** HAVE YOU FILLED IN YOUR PREVIOUS VACCINATIONS ABOVE? IF NOT, PLEASE TAKE A MOMENT TO DO SO.**

Thank You.

08/2008