PASSPORT HEALTH®

Appointment Date: ____________________

CLIENT INTAKE FORM

PERSONAL DATA (PLEASE PRINT CLEARLY)

NAME: ______________________________ DOB: ____________ AGE: ______ SEX: M ☐ F ☐
Last Name First Name MI

HOME ADDRESS: ______________________________ ____________ ______ ______
Street City State Zip

PHONE # ____________ ____________ ____________ E-MAIL ____________________
Home Office Cell

EMPLOYER: ____________________ OCCUPATION: ____________________

EMERGENCY CONTACT: ____________________ ____________________ ____________________
Name Relationship Phone Number

PRIMARY CARE PHYSICIAN /PHARMACY INFORMATION

NAME:	PHONE:
ADDRESS:	
It is recommended that your physician have a copy of immunizations you receive – as a courtesy, would you like us to send your physician a copy of your immunization record?	YES ☐ NO ☐
PHARMACY:	PHONE:

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:

☐ TOURIST	☐ BUSINESS	☐ STUDENT	☐ TEACHER	☐ ENTERTAINMENT/PERFORMER
☐ ADOPTION	☐ MISSIONARY	☐ RELIEF WORK	☐ CRUISE SHIP	☐ YOUTH HOSTEL
☐ SMALL HOTELS	☐ MAJOR RESORT	☐ STAYING WITH FAMILY	☐ RENTED HOME	☐ CAMPING
☐ SAFARI	☐ CLIMBING	☐ DIVING	☐ RURAL TRAVEL AT ANY TIME	

Are you traveling: ☐ With your Company? ☐ In a group? ☐ With your school? How many in your group? ____________

Who arranged your trip:

Name____________________ **Tel** ____________ **e-mail** ____________________

How did you hear about Passport Health?

☐ RETURN CLIENT	☐ PHYSICIAN	☐ EMPLOYER	☐ FRIEND/FAMILY
☐ INTERNET SEARCH	☐ CDC WEBSITE	☐ PASSPORT HEALTH WEBSITE	☐ OTHER WEBSITE
☐ SCHOOL/COLLEGE	☐ TRAVEL AGENT	☐ RELIEF ORGANIZATION	☐ HEALTH DEPT
☐ TRAVISA	☐ CHURCH/MISSION GROUP	☐ CONSULATE/EMBASSY	☐ OTHER

____
Please Indicate Name of Referral

May we contact you after your trip regarding your health for possible research? YES ☐ NO ☐

Would you like to receive information regarding health alerts, outbreaks, & vital travel information? YES ☐ NO ☐

Please complete the back page

MEDICAL HISTORY

Question	Yes	No	Question	Yes	No
Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?	☐ Yes	☐ No	Are you allergic to bee stings?	☐ Yes	☐ No
Do you have high blood pressure or take high blood pressure medicine?	☐ Yes	☐ No	Do you have diabetes? If yes, do you take insulin? ☐ Yes ☐ No	☐ 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
Do you have lung disease, asthma, or chronic bronchitis/shortness of breath?	☐ Yes	☐ No	Do you have a history of depression or psychiatric disorders?	☐ Yes	☐ No
Are you currently experiencing any respiratory infections or other acute illness or infections?	☐ Yes	☐ No	Do you have an active nerve disorder? Do you have a history of Guillian-Barre Syndrome?	☐ 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, any person you live with, or any person in your care have cancer, leukemia, AIDS, or any other immune system problem?	☐ Yes	☐ No	Do you, any person you live with, or any person in your care take any cortisone, prednisone steroids, chemotherapy, or radiation therapy?	☐ Yes	☐ No
Do you have stomach/bowel conditions such as frequent diarrhea or constipation?	☐ 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 past three (3) months have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐ Yes	☐ No

Are you allergic to any drug, medication, vaccine or vaccine component, thimerosol or mercury (a preservative)? ☐ **Yes** ☐ **No**

If yes, what are you allergic to? ___________________________________

____

Are you currently taking any medications including oral contraceptives and blood pressure medication? ☐ **Yes** ☐ **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.)

____

____

QUESTIONS FOR WOMEN

Are you pregnant? ☐ Yes ☐ No

Do you plan to become pregnant within the next three months ☐ Yes ☐ No

Are you breastfeeding (nursing) now? ☐ Yes ☐ No

Do you have problems with vaginitis? ☐ Yes ☐ No

Prior Immunization Dates: Please provide year of vaccination

Tetanus/Diphtheria / Tdap(Tetanus/Diphtheria/Pertussis) ___________

Yellow Fever ___________ Meningitis _____________

Influenza ___________ Varicella ____________

Pneumonia ___________ MMR ____________

PPD /TB TEST ___________ Polio _____________

Typhoid _____________ ☐ Injection ☐ Pills

Hep A________ # Doses ____ Hep B________ # Doses _____

Twinrix _______ # Doses ____ Rabies _______ # Doses ____

Japanese Encephalitis _________ # Doses ____

Malaria Medication: _________________________________(name)

☐ **Copy of immunization record provided to Passport Health nurse**

The above information is true and accurate to the best of my knowledge. I understand that insurance may not cover these services and I am responsible for all fees associated with this visit. Passport Health is not a Medicare provider and does no insurance billing or filing of forms, including pre-authorization for medications. Payment is due at time of service by cash, debit card or credit card. I understand I will be 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/PATIENTSIGNATURE _______________________________________ **DATE** ____________________

(under 18 years of age must have Parent/Guardian signature)