

PASSPORT HEALTH PATIENT INFORMATION/CONSENT

rev.05/09

Cincinnati Area Locations in: Blue Ash, West Chester, Anderson & Ft. Wright, KY

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

BIRTHDATE: _____ AGE: _____ SEX: MALE FEMALE HOME PHONE: (____) _____

Soc. Sec. #: _____ CELL or WORK PHONE: (____) _____

If we may use to contact you: E-MAIL: _____ Fax: (____) _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT: _____
Name Relationship Phone

WHERE HEARD ABOUT PASSPORT/REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS/LOCATION: _____

Do you want us to send your primary care physician a copy of your immunization record? yes no

PHARMACY NAME _____ PHONE _____

Where are you going? (List individual countries in sequence of visit) _____

Length of stay: _____ Leaving: _____ Returning: _____

Purpose of Travel: _____

Current or chronic physical or mental illnesses: _____

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

No known allergies to medications. Medication allergy to: _____

List vaccines you have had and dates if known including oral or nasal mist: _____

Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex, or insect/bee stings? yes (circle) no

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

Do you have high blood pressure? yes no If yes, are you on medication? _____

Current medications (including oral contraceptives and anticoagulants): _____

Have you received blood or blood products or immune globulin in past year? yes no _____

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

Do you have a history of thymus disorder or dysfunction, including myasthenia gravis, thymoma, thymectomy, or DiGeorge syndrome? yes no _____

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? _____

Are you traveling against the recommendation of a physician? yes no If yes, what is the condition? _____

The above information is accurate to the best of my knowledge. 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 and does no insurance billing or filing of claims. 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: _____ **Date:** _____