

**PASSPORT HEALTH PATIENT INFORMATION/CONSENT**

rev.7/10

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 Last 4 digits of Soc. Sec. #: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_ WORK PHONE:(\_\_\_\_) \_\_\_\_\_

Please check numbers above where we can leave messages.

E -MAIL (If we may use to contact you) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_  
Street City State Zip

EMERGENCY CONTACT: \_\_\_\_\_  
Name Relationship Phone

Non-Urgent care may be discussed with: \_\_\_\_\_  
Name Relationship Phone

WHERE HEARD ABOUT PASSPORT/REFERRED BY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS/LOCATION: \_\_\_\_\_

**We will send your primary care physician your immunization record unless you check here. no don't send**

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:** \_\_\_\_\_