# PASSPORT HEALTH TRAVEL PATIENT QUESTIONNAIRE

PERSONAL DATA (PLEASE PRINT CLEARLY)

_____ _____ _____
Last Name First Name Middle Initial

HOME ADDRESS:

_____ _____
Street Apt #

_____ DOB _____ AGE _____ SEX M ☐ F ☐
City State Zip

E-MAIL ADDRESS _____

PHONE # _____ _____ _____
Home Office Cell

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: ☐ Health Dept. ☐ Physician ☐ CDC ☐ Website ☐ Friend/Family ☐ Other _____

EMERGENCY CONTACT

_____ _____ _____
Name Relationship Phone Number

PRIMARY CARE PHYSICIAN _____ PHONE: _____

ADDRESS LOCATION: _____

May we send your primary care physician a copy of your immunization record? **(Please list physician and address above.)**
YES ☐ NO ☐

## TRAVEL INFORMATION

| PLEASE LIST THE COUNTRIES YOU ARE TRAVELING TO IN ORDER | APPROXIMATE LENGTH OF STAY IN EACH COUNTRY |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

DEPARTURE DATE_____ RETURN DATE_____

REASON FOR TRAVEL ☐ TOURIST ☐ BUSINESS ☐ STUDENT ☐ OTHER _____
ACCOMODATIONS ☐ HOTEL ☐ YOUTH HOSTEL ☐ FAMILY/HOME ☐ CRUISE ☐ CAMPING ☐ OTHER _____

| | |
|---|---|
| Do you plan to visit only tourist areas or major cities? | ☐ Yes ☐ No |
| Do you plan to visit rural areas? | ☐ Yes ☐ No |
| Do you plan to visit rural areas during evening or nighttime hours? | ☐ Yes ☐ No |
| Do you plan to go hiking or backpacking? | ☐ Yes ☐ No |
| Do you plan to go bicycling? | ☐ Yes ☐ No |
| Do you plan to go swimming? | ☐ Yes ☐ No |
| If yes, Chlorinated Pool ☐ Fresh Water Lake or Stream ☐ Ocean ☐ | |
| Do you plan to travel or to climb to high altitudes? | ☐ Yes ☐ No |
| Do you plan to scuba dive? | ☐ Yes ☐ No |
| If yes. Are you certified? | ☐ Yes ☐ No |
| When is air travel scheduled after last dive? _____ | |

| Please check yes or no | | | Please check yes or no | | |
|---|---|---|---|---|---|
| Do you have heart problems?<br>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 | Are you allergic to eggs, yeast, or any other foods? | ☐ Yes | ☐ No |
| Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy? | ☐ Yes | ☐ 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). | ☐ Yes | ☐ No |
| Do you have lung disease, asthma, chronic bronchitis, or shortness of breath? | ☐ Yes | ☐ No | Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS, or any other immune system problem? | ☐ Yes | ☐ No |
| Do you have a stomach or bowel condition, such as bowel irritability, frequent diarrhea or constipation? | ☐ Yes | ☐ No | Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today? | ☐ Yes | ☐ No |
| Do you have any skin condition such as psoriasis, eczema or shingles? | ☐ Yes | ☐ No | Have you ever fainted from an injection or from having your blood drawn? | ☐ Yes | ☐ No |
| Do you experience nightmares or insomnia? | ☐ Yes | ☐ 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: _____<br>_____ | ☐ Yes | ☐ No |
| Do you have a history of depression or psychiatric disorders? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| Do you have Diabetes?<br>If yes, do you take insulin? Yes No | ☐ Yes | ☐ No | Have you received any vaccinations in the past 4 weeks?<br>If yes, please specify _____ | ☐ Yes | ☐ No |
| Do you have tuberculosis? Have you ever tested positive for tuberculosis? | ☐ Yes | ☐ No | Are you prone to motion sickness? | ☐ Yes | ☐ No |
| Do you have an active nerve condition? Do you have a history of Guillian-Barre Syndrome or seizures? | ☐ Yes | ☐ No | Have you ever had headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet? | ☐ Yes | ☐ No |
| **Are you allergic to any drug, medication, vaccine, or vaccine component, such as penicillin, Themerisol, formalin, sorbitol, codeine, animal serum?**<br>**☐ Yes ☐ No**<br>**If yes, what are you allergic to?** | | | Are you currently taking any medications including oral contraceptives and blood pressure medication? ☐ Yes ☐ No<br>If yes, please list: | | |

**PREVIOUS IMMUNIZATIONS: Please indicate date (year) you received your last immunization for:**

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

**QUESTIONS FOR WOMEN**

| | | | | | |
|---|---|---|---|---|---|
| Are you pregnant? | ☐ Yes | ☐ No | Are you breastfeeding (nursing) now? | ☐ Yes | ☐ No |
| Do you plan to become pregnant within the next three months | ☐ Yes | ☐ No | Do you have problems with vaginitis? | ☐ Yes | ☐ No |

**The above information is accurate to my best recollection. Inactive records are kept on file for 3 years.**

**I understand Passport Health is not a Medicare provider and does no insurance billing or filing of claims (all insurances). I am responsible for all fees due at time of service.**

TRAVELER/PATIENT SIGNATURE _____ DATE _____