



## MEDICAL HISTORY

Please circle yes or no

Please circle 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	Do you have diabetes? If yes, do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	<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 have tuberculosis, or tested positive for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have lung disease, asthma, or chronic bronchitis/shortness of breath?	<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
Are you currently experiencing any respiratory infections or other acute illness or infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have an active nerve disorder? Do you have a history of Guillian-Barre Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any skin diseases or psoriasis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you prone to motion sickness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience nightmares or insomnia?	<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, any person you live with, or any person in your care have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you, any person you live with, or any person in your care take any cortisone, prednisone steroids, chemotherapy, or radiation therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have stomach/bowel conditions such as frequent diarrhea or constipation?	<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
Have you ever traveled internationally (other than Canada)? If yes, did you get ill? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were your symptoms? <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Infection	<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 a medicine called immune globulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to any drug, medication, vaccine or vaccine component, thimerosal or mercury (a preservative)? <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 _____ _____		
Are there <b>ANY</b> other health concerns or issues that we should know about? (Anxiety attacks, fear of needles, claustrophobia, etc.)  _____ _____			<b>Prior Immunization Dates:</b> Tetanus/Diphtheria _____ Polio _____ Yellow Fever _____ Meningitis _____ Influenza _____ Varicella _____ Pneumonia _____ MMR _____ PPD _____ Typhoid _____ Injection/Pills _____ Hep A _____ # Doses _____ Hep B _____ # Doses _____ Twinrix _____ # Doses _____ Rabies _____ # Doses _____ Japanese Encephalitis _____ # Doses _____ Antimalarial? _____ (name) <input type="checkbox"/> Copy of immunization record provided to Passport Health nurse		
<b>QUESTIONS FOR WOMEN</b>					
Are you pregnant? <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 Are you breastfeeding (nursing) now? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have problems with vaginitis? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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. Payment is due at time of service by cash, check, 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)