PASSPORT HEALTH PATIENT INFORMATION/CONSENT

NAME:_____
Last First Middle Initial

ADDRESS:_____
Street City State Zip

BIRTHDATE:_____ AGE:_____ SEX: ☐MALE ☐FEMALE

E-MAIL:_____ HOME TEL:_____

EMERGENCY CONTACT:_____
Name Relationship Telephone

EMPLOYER:_____ WORK PHONE:_____

EMPLOYER ADDRESS:_____
Street City State Zip Code

OCCUPATION:_____

REFERRED BY: ☐ Health Dept ☐ Physician ☐ Internet site_____ ☐ Yellow Pages

PRIMARY CARE PHYSICIAN:_____PHONE:_____

ADDRESS/LOCATION:_____

Do you want us to send your primary care physician a copy of your immunization record? ☐yes ☐no
May we contact you after your trip regarding your health for possible research? ☐yes ☐no

Places to be visited

Country	**Town**	**Rural Area**	**Dates**
		Yes No	From To
		Yes No	From To
		Yes No	From To
		Yes No	From To
		Yes No	From To

If you have motion sickness, what have you used in the past?_____

The above information is accurate to my best recollection. 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. 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: _____

PLEASE TURN OVER AND FILL OUT OTHER SIDE

PASSPORT HEALTH MEDICAL QUESTIONNAIRE

NAME:_____
Last First Middle Initial

Current medications (including oral contraceptives and blood pressure medication):_____
_____
_____

Do do you have a fever today?_____
If "yes", rate your sickness: MILD MODERATE SEVERE

Does your medical insurance cover prescription medicines? YES☐ NO☐

Chronic physical or mental illness_____
History of Guillain-Barre Syndrome_____
History of jaundice or hepatitis:_____
Have you ever fainted from a shot?_____
Have you had the Chicken Pox disease?_____

Please check yes, no or don't know to the following questions:	Yes	No	DontKnow
Do you have allergies to medications, food or any vaccine (e.g. eggs, antibiotics, sulfa medications, yeast, latex)? If yes, allergy to:			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have cancer, leukemia, AIDS or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?			
During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
Have you received any vaccinations in the past 4 weeks?			
For women: Are you pregnant? If yes, number of months pregnant:_____			
Pregnancy likely within 3 months?			
Are you currently breastfeeding?			
Are you traveling against the recommendation of a physician? If yes, what is the condition?			
Have you eaten today? Please advise the nurse.			

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

Traveler/Parent/Guardian Signature:_____ DATE: _____

For Office Use Only:

Last doses:
Tetanus/Diphtheria:_____ Polio:_____ Typhoid:_____ Injection/Pills
Started Series?
Hep A? _____ # doses:_____ TWINRIX?_____ # doses:_____
Hep B?_____ # doses:_____