PASSPORT HEALTH-TRIANGLE PATIENT INFORMATION/CONSENT

Name: _____ **Gender: O Male O Female**
(FIRST) (MIDDLE) (LAST)

Birth Date _____/_____/_____ **Have you visited Passport Health before? O Yes O No**
(MM/DD/YYYY)

What is the main reason for your visit today? O Travel O Booster O Physical O Other_____

Are you currently employed? O No O Yes Employer Name _____

Enter your phone number where we may contact you for confirmations, questions.

Primary _____-_____-_____ Secondary _____-_____-_____

Emergency Contact: Name_____Relationship_____Phone___-____-_____

Your Home Address: _____
(STREET) (CITY) (STATE) (ZIP)

May we contact you via e-mail? O No O Yes E-mail Address :_____

Would you like us to send your primary care physician a copy of your immunization record? O No O Yes

PRIMARY CARE PHYSICIAN: _____PHONE:_____-_____-_____

ADDRESS/LOCATION: _____
(STREET) (CITY) (STATE) (ZIP)

Pharmacy Information: Name_____ Phone___-____-_____

Address_____
(STREET) (CITY) (STATE) (ZIP)

How did you hear about Passport Health? O Physician O Internet O Company/Employer O Other

Referral Name: _____

Purpose of Trip: O Business O Pleasure O Mission O Study Abroad O Adoption

O Other_____

Date Leaving USA: _____/_____/_____ **Date Returning to USA _____/_____/_____**
(MM/DD/YYYY) *(MM/DD/YYYY)*

To which countries are you traveling? *(Please list countries in the order of your visit)*

1:_____ _____ ***Country # Days***
2:_____ _____ ***Country # Days***
3:_____ _____ ***Country # Days***

4:_____ _____ ***Country # Days***
5:_____ _____ ***Country # Days***
6:_____ _____ ***Country # Days***

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Past Medical History:

Please check the Conditions for which you have been treated:

☐ Cancer ☐ Atherosclerosis ☐ HIV/AIDS ☐ Psychiatric Conditions ☐ Thymus Removal ☐ Thyroid Disease

Select any additional conditions for which you are being treated:

□ Acid Reflux □ Anxiety/Depression □ Asthma □ Arthritis □ Diabetes □ Epilepsy □ Gastrointestinal Disease □ Heart Disease

□ Hepatitis □ High Blood Pressure □ Kidney Disease □ Liver Disease □ Migraine Headaches □ Neurological □ Rheumatoid Arthritis □ Tuberculosis

Do you have eczema, psoriasis, or other chronic dermatitis? □ Yes □ No

Are you receiving steroid medications such as cortisone or prednisone? □ Yes □ No

Which steroid medications are you taking?_____

Do you have a previous history of tendonitis/tendon rupture? □ Yes □ No

Do you have any known drug allergies? □ Yes □ No Drug Allergy _____

Are you allergic to any of the following:

□ Eggs □ Feathers □ Formaldehyde □ Insect/Bee Stings □ Latex □ Mercury □ Quinine □ Thimerosal □ Yeast □ Other (Please List) _____

Are you receiving radiation or other treatments? □ Yes □ No

Have you ever had a reaction to an immunization in the past? □ Yes □ No

Please provide name of immunization to which you had a reaction. _____

Have you ever had a positive TB skin test? □ Yes □ No

Do you have any history of Guillain-Barre syndrome or paralysis? □ No □Yes What Type_____

Do you have any history of motion sickness? □ No □Yes What have you used previously_____

Have you ever taken malaria pills? □ Yes □ No

If you experienced any side effects please list them here: _____

Select the vaccines and date you have received in the past:

□ **Hepatitis A** _____ (Date) □ **Hepatitis B**_____ (Date) □ **Twinrix** *(Hep A/B Combo)* _____ (Date) □ **HPV (Gardasil)** _____ (Date) □ **Influenza** _____ (Date)

□ **Japanese Encephalitis** _____ (Date) □ **MMR** _____ (Date) □**Meningitis**_____ (Date) □ **Polio** _____ (Date) □ **Rabies** _____ (Date)

□ **Tetanus Diphtheria** _____ (Date) □ **T/d Pertussis** _____ (Date) □ **Typhoid** *(Oral or Injection)* _____ (Date) □ **Chicken Pox** *(Varicella)* _____ (Date)

□ **Shingles** *(Zostavax)* _____ (Date) □ **Anthrax** _____ (Date) □ **Immune Globulin** _____ (Date) □ **Other** _____ _____ (Date)

MEDICATION/SUPPLEMENT USE

Do you take medications (prescription and non-prescription)? □ No □ Yes Please List _____

WOMEN'S MEDICAL HISTORY

□ **Are you pregnant now? Yes □ No Are you currently breastfeeding? □ Yes □ No**

CLIENT ACKNOWLEDGEMENT

□ **Client has read the HIPAA Policy and Consent Form**

Signature_____ **Date** _____

□ ***Parent/Guardian?*** **(only adults 18 or over should sign this form)**