PASSPORT HEALTH®

Updated 10.29.14

Patient Information/Medical History

Name:____
First Middle Last

Weight:______________ Gender: M /F Date of Birth:_______________ Age:_____

Address: ____City_____________state______zip___________

Email: _____________________________Phone: ___________________________________

Emergency Contact Name: _____________________Phone:_________________ Relationship:_________

Current Employer : _____________________________

Have you been to a Passport Health Before Y /N (If , which location:___________________________)

Name of Primary care provider: ____

Would you like your vaccine record sent to your doctor named above? Yes No

Pharmacy Name: _____________________________________ Pharmacy Phone:_____________

Pharmacy Address/Cross Streets: ______________________

Select the conditions for which you have been treated:

Condition	Yes	No
Cancer	Yes	No
Atherosclerosis	Yes	No
HIV/AIDS	Yes	No
Psychiatric Condition	Yes	No
Thymus Removal	Yes	No
Thyroid Disease	Yes	No

If yes to any of these questions, please describe here:

Select any additional conditions for which you are being treated

Condition	Yes	No
Acid Reflux	Yes	No
Anxiety/Depression	Yes	No
Asthma	Yes	No
Arthritis	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Gastrointestinal disease	Yes	No
Heart disease	Yes	No
Hepatitis	Yes	No
High blood pressure	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Migraines/headaches	Yes	No
Neurological	Yes	No
Rheumatoid arthritis	Yes	No
Tuberculosis	Yes	No
Eczema, psoriasis, or other chronic dermatitis	Yes	No
Any history Of Guillain-Barre Syndrome or paralysis	Yes	No

If yes to any of these questions, please describe here:

Other ____

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Other Medical Concerns

Are you receiving steroid medications such as cortisone or prednisone	Yes	No
Do you have a previous history of tendonitis/tendon rupture?	Yes	No
Are you receiving radiation or other treatments?	Yes	No
Do you have a history of fainting with shots?	Yes	No
Do you have any history of motion sickness?	Yes	No
Are you caring for anyone who is immunocompromised?	Yes	No
Have you ever had a positive TB skin test?	Yes	No
Do you have heart problems or cardiac arrhythmia or irregularity?	Yes	No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	Yes	No
Are you currently experiencing any respiratory infections, or other acute illness or infection?	Yes	No
Do you experience nightmares or insomnia?	Yes	No
Do you have stomach/bowel conditions such as frequent diarrhea or constipation?	Yes	No

Allergies

Do you have any known drug allergies? Yes No

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

Are you allergic to:

Eggs	Yes	No
Feathers	Yes	No
Formaldehyde	Yes	No
Gelatin	Yes	No
Insect/Bee stings	Yes	No
Latex	Yes	No
Mercury	Yes	No
Quinine	Yes	No
Thimerosal	Yes	No
Yeast	Yes	No

Other ____

If yes, what was the reaction?

Malaria:

Have you taken Malaria Pills Yes No Which One?________________________________

Vaccine History

Please list the Vaccines you have received in the past with estimated date

____

____

____

____

Have you **received ANY vaccines in the past month**? Yes No

Current Medications

Please list the Medications you are currently taking (prescription and non-prescription)

____

____

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Women's Health

Are you, or is there any chance you may be, currently pregnant?	Yes	No
Are you planning on becoming pregnant within 3 months?	Yes	No
Do you take birth control pills?	Yes	No
Are you currently breastfeeding?	Yes	No

If you are traveling out of the country please complete the following:

Trip purpose : Adoption   Business   Mission
Pleasure   Student   Volunteer   Other___________________

Date leaving the US: ______________   Date returning to US:___________________

Please list the countries you are visiting   Length of stay

____   _______________
____   _______________
____   _______________
____   _______________

Please circle any of the following activities you will be doing any during your trip

SCUBA Dive   Mountain Climbing   Stay in Rural Areas
Camping   Working with Animals   Medical Work

Notes:

Client Acknowledgement:
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. I have read/received the HIPAA/Consent Policy

Signature _____________________________________ **Date**___________

☐ Parent/Guardian (Only adults 18 years or older should sign this form)

*****FOR NATIONAL ACCOUNT CLIENTS ONLY *****

I hereby authorize and request Passport Health, and/or its affiliates and franchisees as applicable, to periodically transmit my personal health information to my employer, physically, via facsimile, or electronically as circumstances permit. This is an ongoing authorization and request and applies to any and all personal health information obtained by Passport Health and/or its affiliates and franchisees, at present and in the future. I understand and accept that there are security risks inherent in using electronic means to communicate protected health information, including, but not limited to, electronic capture of the message en route. I further understand and accept that Passport Health cannot guarantee the security of systems external to Passport Health through which messages may be transmitted.

Signature _____________________________________ **Date**___________