

# 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

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? \_\_\_\_\_

<b>Please check yes, no or don't know to the following questions:</b>	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?			
<b>For women:</b> 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:

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