PASSPORT HEALTH PATIENT INFORMATION/CONSENT
Part I

NAME:____
Last First Middle Initial

ADDRESS:____
Street City State Zip

DATE TODAY:_______________ BIRTHDATE:_____/____/______AGE:__________ SEX: ☐Male ☐Female
Month Date Year

HOME PHONE#:_____________________CELL PHONE#:_____________________LAST 4 OF SS#________________

HAVE YOU BEEN HERE BEFORE? ☐Yes ☐No WHEN?_______________________________________

EMPLOYER:____ WORK PHONE: _______________________________

REGISTER TO RECEIVE OUR FREE E-ZINE, HEALTH ALERTS, TRAVEL NEWS & HOT TRAVEL DESTINATION INFORMATION? ☐yes ☐no **EMAIL:** ____

PRIMARY CARE PHYSICIAN:____PHONE:_______________________

ADDRESS/LOCATION:____
Do you want us to send your primary care physician a copy of your immunization record? ☐yes ☐no

Where are you going? (Please List Countries in Order)	Approximate Length of Stay in Each Country

Departure Date_________________________________ Return Date____

Chronic physical or mental Illnesses:____
Do you have eczema or other chronic dermatitis? ☐yes ☐no If yes, type___________________________________
Previous History of tendonitis/tendon rupture ☐yes ☐no
☐ No known allergies to medications. ☐ Medication allergy to:____
List all recent vaccines you have had and dates if known including oral or nasal mist:______________________________
____
Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?__________________________
Motion Sickness? ☐yes ☐no If yes, what have you used in the past?____
Do you have high blood pressure? ☐yes ☐no If yes, are you on medication?___________________________________
Current medications (including oral contraceptives or anticoagulants):_______________________________________
____
Are you receiving steroid medications such as cortisone or prednisone? ☐yes ☐no If yes, type______________________
Are you receiving radiation or other treatments? ☐yes ☐no If yes, type____
Are you pregnant now or is there a possibility that you might be pregnant? ☐yes ☐no If yes, months__________________
Have you had an allergic reaction to an immunization in the past? ☐yes ☐no If yes, what?__________________________

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:____

PLEASE CONTINUE TO THE BACK OF THIS PAGE

PASSPORT HEALTH PATIENT INFORMATION/CONSENT
Part II

To Allow Us to Serve you Better, Please Provide The Information Below:

How Did You Hear About Us

☐Return Client ☐ Friend
☐Family Member
☐Primary Care Physician
☐Passport Health Client
☐Pharmacist
☐Travel Agent
☐Company Travel Manager
☐School/College Nurse
☐CDC Site
☐Health Department
☐TV/Cable Advertisement ____________ Channel/Network
☐Direct Mail ____________ Promotional Code
☐Internet Ad where? ____________ Website
☐Internet Search ____________ Search Engine
☐Other Internet Site ____________ Website
☐Radio ____________ Station
☐ Other ____________ Please Specify

SO THAT WE MAY SEND A THANK YOU, PLEASE TELL US MORE ABOUT THE PERSON WHO REFERED YOU

____________________ EMAIL____________________
Salutation First Name Last Name

____________________ PHONE____________________
Street City State Zip

FOR OFFICE USE ONLY

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Would you be interested in receiving additional information regarding research studies? ☐yes☐no

Purpose of visit ☐Business ☐Leisure ☐Mission ☐Study Abroad ☐Visiting Friends/Family ☐Adoption ☐Other

Are you Traveling ☐Alone? ☐ In a Group? ☐With Your Company? ☐With Your School?

Please rate your initial experience (on a scale of 1 to 5 with 5 being the best)
Phone Professionalism: ____ Appointment Availability: ____ Access to Locations: ____

COMMENTS:____________________

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Thank you for your Visit to Passport Health. Your answers are strictly confidential and they will assist us in our efforts to serve you better.