

PATIENT INFORMATION/CONSENT

(Please answer as completely as possible, both sides)

Date: _____

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Email: _____

Birthdate: _____ Age: _____ Gender: Male Female

Cell Phone #: _____ Home Phone #: _____

Employer: _____ Work Phone #: _____

Occupation: _____

Emergency Contact (& Relationship) _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Address/Location: _____

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

Have you been to Passport Health previously? Yes No Explain: _____

Travel Information? *(List individual countries in sequence of visit)*

Date Leaving _____ Date Returning _____

Purpose of visit: Business Leisure Mission Study Abroad Adoption Other _____

Where are you staying: Major Hotel Family Rural Hotel Safari Camping Other _____

**If a MISSION TRIP, what church/organization: _____

How Did you hear about Passport Health (Referred By): *Please check box and provide details.*

Physician Referral Physician name: _____

Internet Search engine or site: _____

Other Please detail: _____

Passport Health is not a Medicare provider and does not bill insurance.

Payment Options: Visa • MasterCard • Discover • American Express • Personal Check • Cash



(Please answer as completely as possible, both sides)

PERSONAL HEALTH HISTORY

Medications/Supplements

List medications or supplements you are currently taking

Allergies

No known allergies to medications

<input type="checkbox"/> I am allergic to the following medications		
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Formaldehyde	<input type="checkbox"/> Quinine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Gelatin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Bee Sting	<input type="checkbox"/> Latex	<input type="checkbox"/> Thimerosal
<input type="checkbox"/> Eggs	<input type="checkbox"/> Mercury	<input type="checkbox"/> Yeast
<input type="checkbox"/> Feathers	<input type="checkbox"/> Neomycin	<input type="checkbox"/> Other _____

Check (✓) if you have had any of the following:

<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> MRSA/VRE
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease/Failure	<input type="checkbox"/> Motion Sickness
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Chronic Dermatitis	<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tendonitis/Tendon Rupture
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	_____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Lung Disease	_____
<input type="checkbox"/> Guillain-Barré	<input type="checkbox"/> Lupus Erythematosus	_____

Have you had any vaccines in the last 4 weeks? Yes No

Have you ever had an allergic reaction to immunizations or vaccines in the past? Yes No

If Yes, name and reaction: _____

Do you have a chronic physical illness? Yes No If Yes, explain: _____

Have you ever or are you currently being treated for depression /mental illness? Yes No

If Yes, Explain: _____

If Yes, Please Explain

Are you currently receiving radiation or chemotherapy? Yes No _____

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

Are you pregnant or is there any possibility that you may be pregnant? Yes No _____

Are you planning on conceiving in the next 6 months? Yes No _____

Please list any vaccines that you have had with dates (including influenza): _____

I agree that the above information is accurate to the best of my knowledge and this form serves as my consent to receive a consultation and necessary vaccines. The nurse has informed me of all the risks associated with the travel medicine and vaccinations as associated with my health history. I completely understand the benefits and risks of the travel medicine and vaccinations and request that the vaccines be given to me. I understand medications and vaccines may not provide 100% protection. I clearly release from any liability PASSPORT HEALTH and the individual giving the vaccine(s). 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 and does not bill insurance. Payment is due at the time of service by check, cash or credit card (\$45 fee for all returned checks).** I understand I will receive documentation of all travel medicine and vaccinations received and I am responsible for keeping the record in a safe place and up-to-date. Passport Health keeps records on file for 5 years. I understand and have had the opportunity to read the HIPAA Form. Medical records will only be released with written consent from the client.

Traveler/Parent/Guardian Signature: _____ Date: _____