

PASSPORT HEALTH PATIENT INFORMATION/CONSENT

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ CELL #: _____

E-MAIL: _____

BIRTHDATE: _____ AGE: _____ SEX: MALE FEMALE

EMPLOYER: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____
Street City State Zip

OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS/LOCATION: _____

Do you want us to send your primary care physician a copy of your immunization record? yes no

PHARMACY NAME: _____ PHONE: _____

Where are you going? (List individual countries in sequence of visit) _____

Length of stay: _____ Leaving: _____ Returning: _____

Purpose of visit to country: _____

Have you ever had any of the following: physical conditions (e.g. heart or lung conditions, diabetes), mental conditions (e.g. anxiety or depression), serious disease (e.g. cancer)? yes no If yes, please explain _____

Do you have **eczema** or other chronic skin conditions? yes no If yes, type: _____

No known allergies to medications Medication allergy to: _____

List 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): _____

Have you received blood or blood products or immune globulin in the past year? yes no If yes, type _____

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 _____

Do you have a history of thymus disorder or dysfunction, including myasthenia gravis, thymoma, thymectomy, or DiGeorge syndrome? yes no If yes, type _____

Are you pregnant now or is there a possibility that you might be pregnant? yes no Most recent period _____

Have you had an allergic reaction to an immunization in the past? yes no If yes, what? _____

Are you traveling against the recommendations of a physician? yes no If yes, what is the condition? _____

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: _____

Remember: Please eat before your appointment. If you have not eaten recently, let the nurse know. Over ->



PASSPORT HEALTH
First Class Medical Care For Travel Anywhere

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
- Primary Care Physician
- Passport Health Client
- Pharmacist
- Travel Agent
- Company Travel Manager
- School/College Nurse
- CDC Site
- Health Department
- TV/Cable Advertisement _____
- Direct Mail _____
- Internet Ad where? _____
- Internet Search _____
- Other Internet Site _____
- Radio _____
- Other _____

Channel/Network _____
 Promotional Code _____
 Website _____
 Search Engine _____
 Website _____
 Station _____
 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

Street City State Zip PHONE _____

FOR OFFICE USE ONLY

Would you like to receive information regarding Health Alerts, Outbreaks, & Vital Travel info via an online newsletter from Passport Health (E-Zine)? 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: _____

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.