



PASSPORT HEALTH
First Class Medical Care For Travel Anywhere

PASSPORT HEALTH CLIENT INFORMATION/CONSENT
Part I

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

DATE TODAY: _____ BIRTHDATE: _____ / _____ / _____ AGE: _____
Month Date Year

HOME PHONE: _____ SEX: Male Female

HAVE YOU BEEN HERE BEFORE? Yes No WHEN? _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ WORK PHONE: _____
Street City State Zip

For continuity of care, it is important for your physician to receive documentation of your vaccines. Do we have your permission? Yes No

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS/LOCATION: _____

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 _____

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 and dosage: _____

Are you receiving radiation or other treatments? Yes No If yes, type _____

Females: 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 that I will receive vaccines and all appropriate documentation. I 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

