

# PASSPORT HEALTH PATIENT INFORMATION/CONSENT

NAME: \_\_\_\_\_  
Last First Middle Initial

ADDRESS: \_\_\_\_\_  
Street City State Zip

E-MAIL: \_\_\_\_\_ CELL #: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  MALE  FEMALE

SOCIAL SECURITY #: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_  
Street City State Zip

OCCUPATION: \_\_\_\_\_

REFERRED BY:  Health Department  Physician  CDC  Website  Family/Friend  Other \_\_\_\_\_

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 via e-mail regarding your travel experience or possible research?  yes  no

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

Length of stay: \_\_\_\_\_ Leaving: \_\_\_\_\_ Returning: \_\_\_\_\_

Purpose of visit to country: \_\_\_\_\_

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 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: \_\_\_\_\_ Date: \_\_\_\_\_

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