



PATIENT INFORMATION/CONSENT

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

BIRTHDATE: ____/____/____ AGE: _____ SEX: Male Female
Month Date Year

HOME PHONE#: _____ CELL PHONE: _____

Email: _____

HAVE YOU BEEN HERE BEFORE? Yes No WHEN? _____

Referred by: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ WORK PHONE _____
Street City State Zip

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)	Aproximate Length of Stay in Each Country
_____	_____
_____	_____
_____	_____

Departure Date _____ **Return Date:** _____

Reason for travel: vacation/ business/ mission work

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 _____

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. Medications are not returnable per State Law.

Traveler/Parent/Guardian Signature: _____

DATE: _____