PASSPORT HEALTH CLIENT INFORMATION/CONSENT

NAME:____
Last First Middle Initial

ADDRESS:____
Street City State Zip

EMERGENCY CONTACT:____________________________________CONTACT #: _________________
Name Relationship

BIRTHDATE:_____________ AGE:______ SEX: ☐MALE ☐FEMALE E-MAIL:______________________

LAST FOUR NUMBERS OF SS:____________ REFERRED BY:___________________________________

CELL PHONE (________)___________________HOME PHONE (________)_______________________

EMPLOYER:____

EMPLOYER ADDRESS: ____
Street City State Zip

OCCUPATION:____

*******Records can only be sent to physician if you write the full address with ZIPCODE. *******

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

PRIMARY CARE PHYSICIAN:_________________________________PHONE:______________________

ADDRESS:____

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

____

Length of stay:____________ Arrival date:___________________________ Returning:____________________

Purpose of Travel:____

Have you received any vaccinations in the last month? If yes, which vaccinations?___________________ ☐**yes** ☐**no**

Have you received blood transfusions or blood products recently?_______________________________ ☐**yes** ☐**no**

Chronic physical or mental Illnesses? If yes, type: ____ ☐**yes** ☐**no**

Do you have eczema or other chronic dermatitis? If yes, type:________________________________ ☐**yes** ☐**no**

Do you have any known allergies to any medications? If yes, type:______________________________ ☐**yes** ☐**no**

Are you allergic to: eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?_____☐**yes** ☐**no**

Do you have a history of thymectomy, myasthenia gravis or thymoma? ___________________________ ☐**yes** ☐**no**

Have you ever had Chicken Pox or Shingles? If yes, which one.__________________________________☐**yes** ☐**no**

Motion Sickness? If yes, what have you used in the past?_____________________________________ ☐**yes** ☐**no**

Do you have high blood pressure? If yes, what medications are you taking?______________________ ☐**yes** ☐**no**

Current medications (including oral contraceptives):____ ☐**none**

____

Are you receiving steroid medications such as cortisone or prednisone? If yes, type_________________ ☐**yes** ☐**no**

Are you receiving radiation or other treatments? If yes, type____________________________________ ☐**yes** ☐**no**

Are you pregnant now or is there a possibility that you might be pregnant? If yes, months_____________ ☐**yes** ☐**no**

Are you breast feeding?____ ☐**yes** ☐**no**

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

Are you traveling against the recommendation of a physician? If yes, what is the condition?___________ ☐**yes** ☐**no**

******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 cash or credit card. I give permission to Passport Health to release medical information to my physician at my direction. I give consent for immunization administration. I understand that it is recommended that I remain in the office for at least 15 minutes following injection. Medications may not be exchanged or returned.

Client Signature/Parent of Guardian if under 18:_________________________________ Today's Date: ___________