



**PASSPORT HEALTH PATIENT INFORMATION/CONSENT : Part I**

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

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

DATE TODAY: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ GENDER: Male Female  
Month Date Year

HAVE YOU BEEN HERE BEFORE? Yes No WHEN? \_\_\_\_\_

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

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

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)	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 \_\_\_\_\_

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/Client/Parent/Guardian Signature: \_\_\_\_\_

**PLEASE CONTINUE TO THE BACK OF THIS PAGE**



# 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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

May we contact you via e-mail? yes no E-MAIL: \_\_\_\_\_

Would you like to receive information regarding Health Alerts, Outbreaks, & Vital Travel info? yes no

Would you be interested in receiving additional information regarding research studies? 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.