

# PASSPORT HEALTH PATIENT INFORMATION/CONSENT

## Please Print

<b>OFFICE USE</b> <input type="checkbox"/> Client entered <input type="checkbox"/> Dr. entered <input type="checkbox"/> Records Sent <input type="checkbox"/> YF  CLIENT INFORMATION REVIEWED BY R.N.  _____
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NAME: \_\_\_\_\_  
Last First Middle Initial

ADDRESS: \_\_\_\_\_  
Street Apartment/Space #  
City State Zip Code

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

SOCIAL SECURITY # LAST 4 ONLY: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
AREA CODE

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
AREA CODE

EMPLOYER ADDRESS: \_\_\_\_\_  
Street Suite #  
City State Zip Code

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

HOW DID YOU HEAR ABOUT PASSPORT HEALTH:  Phonebook  Doctor  DEX Online  Website  
 Family-If we have seen them, what is their name \_\_\_\_\_  Other \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_  
Do you want us to send your primary care physician a copy of your immunization record?  yes  no

**WHERE ARE YOU GOING? Please list individual countries.**

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

Purpose of Travel/Visit: \_\_\_\_\_

Chronic Illnesses: \_\_\_\_\_

Do you have eczema or other chronic dermatitis?  yes  no If yes, Type: \_\_\_\_\_

No known allergies to medications.  Medication allergy to: \_\_\_\_\_

Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde or insect/bee stings?  yes  no

Motion Sickness?  yes  no If yes, what have you used in the past? \_\_\_\_\_

Do you have high blood pressure?  yes  no If yes, what medication(s) are you taking? \_\_\_\_\_

Current medications (including contraceptives): \_\_\_\_\_

Are you receiving steroid medications such as cortisone or prednisone?  yes  no If yes, name: \_\_\_\_\_

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  n/a If yes, months: \_\_\_\_\_

Are you planning to become pregnant within 3 months?  yes  no  n/a

Have you had an allergic reaction to an immunization in the past?  yes  no If yes, what? \_\_\_\_\_

Are you traveling against the recommendation of a physician?  yes  no If yes, what is the condition? \_\_\_\_\_

Have you ever had a positive TB skin test?  yes  no

**I understand that payment for services is expected 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 my consent for immunization administration and understand that I will receive written information about possible side effects. I understand that it is recommended that I remain in the office for at least 15 minutes following an injection. Medications may not be exchanged or returned.**

\_\_\_\_\_  
Client Signature/Parent or Guardian if under 18

\_\_\_\_\_  
Today's Date