PASSPORT HEALTH TRAVEL PATIENT QUESTIONNAIRE

PERSONAL DATA (PLEASE PRINT CLEARLY)

_____ _____ _____
Last Name First Name Middle Initial

HOME ADDRESS:

_____ _____
Street Apt #

_____ _____ _____ DOB _____ AGE _____ SEX M ☐ F ☐
City State Zip

PHONE # _____ _____ _____
Home Office Cell

E-mail ADDRESS _____

EMERGENCY CONTACT

_____ _____ _____
Name Relationship Phone Number

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: ☐ Health Dept. ☐ Physician ☐ CDC ☐ Website ☐ Friend/Family ☐ Other _____

PRIMARY CARE PHYSICIAN _____ PHONE: _____

ADDRESS LOCATION: _____

May we send your primary care physician a copy of your immunization record? YES ☐ NO ☐

May we contact you regarding boosters, medical research or health information regarding your trip? YES ☐ NO ☐

TRAVEL INFORMATION

PLEASE LIST THE COUNTRIES YOU ARE TRAVELING TO IN ORDER	APPROXIMATE LENGTH OF STAY IN EACH COUNTRY
_____	_____
_____	_____
_____	_____
_____	_____

DEPARTURE DATE_____ RETURN DATE_____

REASON FOR TRAVEL ☐ TOURIST ☐ BUSINESS ☐ STUDENT ☐ OTHER _____

ACCOMODATIONS ☐ HOTEL ☐ YOUTH HOSTEL ☐ FAMILY/HOME ☐ CRUISE ☐ CAMPING ☐ OTHER _____

Do you plan to visit only tourist areas or major cities ?	☐ Yes ☐ No
Do you plan to visit rural areas?	☐ Yes ☐ No
Do you plan to visit rural areas during evening or nighttime hours?	☐ Yes ☐ No
Do you plan to go hiking or backpacking?	☐ Yes ☐ No
Do you plan to go bicycling?	☐ Yes ☐ No
Do you plan to go swimming?	☐ Yes ☐ No
If yes, Chlorinated Pool ☐ Fresh Water Lake or Stream ☐ Ocean ☐	
Do you plan to travel or to climb to high altitudes?	☐ Yes ☐ No
Do you plan to scuba dive?	☐ Yes ☐ No
If yes. Are you certified?	☐ Yes ☐ No
When is air travel scheduled after last dive? _____	

NAME_____ _____ _____

LAST FIRST MIDDLE INITIAL

	Please check yes or no			Please check yes or no	
Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?	☐ Yes	☐ No	Are you allergic to bee stings?	☐ Yes	☐ No
Do you have high blood pressure or take high blood pressure medicine?	☐ Yes	☐ No	Are you allergic to eggs, yeast, or any other foods?	☐ Yes	☐ No
Do you have bleeding problems, take anticoagulants, aspirin or aspirin therapy?	☐ Yes	☐ No	Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy (x-ray therapy).	☐ Yes	☐ No
Do you have lung disease, asthma, chronic bronchitis, or shortness of breath?	☐ Yes	☐ No	Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes	☐ No
Do you have a stomach or bowel condition, such as bowel irritability, frequent diarrhea or constipation?	☐ Yes	☐ No	Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today?	☐ Yes	☐ No
Do you have any skin condition such as psioriasis, eczema or shingles?	☐ Yes	☐ No	Have you ever fainted from an injection or from having your blood drawn?	☐ Yes	☐ No
Do you experience nightmares or insomnia?	☐ Yes	☐ No	Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination? If yes, please describe: _____ _____	☐ Yes	☐ No
Do you have a history of depression or psychiatric disorders?	☐ Yes	☐ No	During the past three (3) months have you received a transfusion of blood or plasma, or been given medicine called immune globulin or Rho-gam?	☐ Yes	☐ No
Do you have Diabetes? If yes, do you take insulin? Yes No	☐ Yes	☐ No	Have you received any vaccinations in the past 4 weeks? If yes, please specify _____	☐ Yes	☐ No
Do you have tuberculosis? Have you ever tested positive for tuberculosis?	☐ Yes	☐ No	Are you prone to motion sickness?	☐ Yes	☐ No
Do you have an active nerve condition? Do you have a history of Guillian-Barre Syndrome or seizures?	☐ Yes	☐ No	Have you ever had headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet?	☐ Yes	☐ No
Are you allergic to any drug, medication, vaccine, or vaccine component, such as penicillin, thimerosol , formalin, sorbitol,albumin, animal serum? ☐ Yes ☐ No If yes, what are you allergic to? _____ _____ _____			Are you currently taking any medications including oral contraceptives and blood pressure medication? ☐ Yes ☐ No If yes, please list _____ _____ _____		

**IMPORTANT: PREVIOUS IMMUNIZATIONS: Please indicate "c" for childhood series completed OR year vaccine received

Chicken Pox	Immune Globulin	Polio	Yellow Fever
Flu	Japanese Encephalitis	Pneumonia	
Hepatitis A	Measles, Mumps, Rubella	Rabies	
Hepatitis B	Meningitis	Tetanus/Diphtheria/Pertussis	
Have you ever taken malaria pills? ☐ Yes ☐ No If yes, did you have any side-effects?			

QUESTIONS FOR WOMEN

Are you pregnant?	☐ Yes	☐ No	Are you breastfeeding (nursing) now?	☐ Yes	☐ No
Do you plan to become pregnant within the next three months	☐ Yes	☐ No	Do you have problems with vaginitis?	☐ Yes	☐ No

IMMUNIZATION RECORD

Did you bring your immunization record with you? If not, we will provide one for you. Always bring this record with you for clinic visits. Make sure all your immunizations are recorded.

The above information is accurate to my best recollection. Inactive records are kept on file for 3 years.
I understand Passport Health is not a Medicare provider and does no insurance billing or filing of claims. I am responsible for all fees due at time of service.

TRAVELER/PATIENT SIGNATURE _____ DATE _____

REMEMBER – PLEASE EAT BEFORE YOUR APPOINTMENT. If you have not eaten recently, let the nurse know.
** HAVE YOU FILLED IN YOUR PREVIOUS VACCINATIONS ABOVE? IF NOT, PLEASE TAKE A MOMENT TO DO SO.
Thank You. 07/2006