PASSPORT HEALTH TRAVEL PATIENT QUESTIONNAIRE

PERSONAL DATA (PLEASE PRINT CLEARLY)

RETURN CLIENT: DATE LAST SEEN _____

If return client, Location Where Seen (circle): Plano Dallas Grapevine Fort Worth McKinney

_____ _____ _____

LAST NAME FIRST NAME MIDDLE NAME

HOME ADDRESS:

_____ _____

STREET APT #

_____ _____ _____ DOB_____AGE_____ SEX MALE FEMALE

CITY STATE ZIP

PHONE #_____ _____ _____

HOME OFFICE CELL

EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

MAY WE CONTACT YOUR HUMAN RESOURCES DEPARTMENT FOR TRAVEL AND OR FLU CLINICS? IF YES, PLEASE GIVE CONTACT NAME:

_____ PHONE: _____

EMERGENCY CONTACT:

_____ _____ _____

NAME RELATIONSHIP PHONE

REFERRED BY: ☐ HEALTH DEPT. ☐ PHYSICIAN _____ ☐ CDC ☐ WEBSITE ☐ OTHER

WOULD YOU LIKE US TO SEND A COPY OF YOUR VACCINATIONS TO YOUR PRIMARY CARE PHYSICIAN? ☐ NO ☐ YES

PHYSICIANS NAME: _____PHONE:_____

ADDRESS: _____

TRAVEL INFORMATION

**PLEASE SKIP AND CONTINUE ON PAGE TWO IF NOT TRAVELING

PLACES TO BE VISITED: (PLEASE NOTE ANY POSSIBLE SIDE TRIPS OR LAY OVERS THAT MIGHT BE INCLUDED IN YOUR TRAVEL PLANS)

COUNTRY	TOWN	RURAL AREAS		DATES: (INCLUDE YEAR)
_____	_____	YES	NO	FROM_____TO_____
_____	_____	YES	NO	FROM_____TO_____
_____	_____	YES	NO	FROM_____ TO_____

PURPOSE OF TRAVEL: _____

PASSPORT HEALTH®
First Class Medical Care For Travel Anywhere

NAME_____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL

Do you have heart problems? Do you have cardiac arrhythmia or irregularity?	Yes	No	Are you allergic to bee stings?	Yes	No
Do you have high blood pressure? Do you take high blood pressure medicine?	Yes	No	Are you allergic to eggs, yeast, or any other foods? What happens?_____	Yes	No
Do you have any bleeding problems? Do you take anticoagulants or aspirin?	Yes	No	Do you or any person you are in close contact with take cortisone, prednisone, steroids or chemotherapy?	Yes	No
Do you have any 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 stomach or bowel conditions, such as Irritable bowel, frequent diarrhea or constipation?	Yes	No	Are you currently experiencing any respiratory infection, acute illness or other infection? Are you sick today?	Yes Yes	No No
Do you have any skin conditions such as Psoriasis, Eczema, or shingles?	Yes	No	Have you ever fainted from an injection or from having you 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 any other psychiatric disorders?	Yes	No	During the past three 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? Insulin dependent?	Yes Yes	No No	Have you received any vaccinations in the past 4 weeks? If yes, please specify:_____	Yes	No
Do you have tuberculosis? Ever had a positive skin test?	Yes Yes	No No	Are you prone to motion sickness? If yes, please specify:_____	Yes	No
Do you have an active nerve condition? Do you have a history of Guillian Barre? Seizure disorder?	Yes Yes Yes	No No No	Have you ever had a headache, dizziness, or felt very short of breath when at altitudes above 6,000 feet? If yes, where? _____	Yes	No
Are you allergic to any medications, vaccines, or vaccine components? PLEASE LIST ALL ALLERGIES:_____ _____ _____	Yes	No	Please list all medications (including over the counter ones) currently being taken, including oral contraceptives and blood pressure medicine. _____ _____ _____		

For Women Only:

Are you pregnant?	Yes	No	Are you breastfeeding now?	Yes	No
Do you plan to become pregnant in the next three months?	Yes	No	Do you have problems with vaginitis?	Yes	No

Previous Immunizations: Please check all that apply and indicate year, if known

Chicken pox	Immune Globulin	Polio	Yellow Fever
Flu	Japanese Encephalitis	Pneumonia	Measles, Mumps, Rubella
Hepatitis A	Hepatitis B	Rabies	Meningitis
Tetanus, Diphtheria, Pertussis			
Have you ever taken Malaria Pills? Yes No	If yes which one? _____	Any side effects? _____	

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/Parent/Guardian Signature: _____ Date_____

Nurse Reviewer's Signature:_____