Patient Registration

Patient's Name (Last, First, Middle Initial)				Date of Birth:	Social Security #	
Address:				City:	State:	Zip:
Age	Sex	Marital Status	Home Phone	Work Phone:		Cell Phone:
Person Responsible for Bill along with their address:				Relationship to Patient:		

Medical History

Immunization (these include childhood vaccinations)

Please circle "YES" or "NO" to the following questions:

Had rubella (German Measles) or received rubella vaccine? **Yes or No**

Had mumps or received mumps vaccine? **Yes or No**

Had measles or received measles vaccine? **Yes or No**

Have you received at least 3 doses of polio vaccine? **Yes or No**

When was your last polio vaccination? _____

Which polio vaccine did you receive? **Oral or Injectable**

Did your last Tetanus shot include Diphtheria? **Yes or No**

Have you had Hepatitis B vaccine? **Yes or No**

When did you receive your last Tuberculin test? _____

Have you received the BCG vaccine for Tuberculosis? **Yes or No**

Have you ever had reactions to immunizations? **Yes or No**

Do you have any allergies to the following items? (Circle all that apply)

Eggs Medicine Antibiotics Mercury (thimerosal) Feathers

Sunlight Grasses or Molds Formaldehyde Vaccines

Are there any other drugs to which you have had an allergic reaction?

(Please list)_____

Are you being treated for leukemia, lymphoma, cancer or any other malignant disease? **Yes or No**

Do you have a history of deficiency of the immune system? **Yes or No**

Do you have a history of anemia or any other blood disorder? **Yes or No**

Do you have any existing medical condition such as diabetes, heart disease, or pulmonary disease? **Yes or No**

If so, please list:_____

Are you on steroids? **Yes or No**

When was your last x-ray performed? _____

_____

WOMEN ONLY

Are you pregnant, suspect you may be pregnant or trying to become pregnant? **Yes or No**

_____

List all medications you are taking, including over-the-counter medications, herbal treatments, natural supplements, and vitamins:

_____

_____

_____

TRAVEL INFORMATION

Date of Departure: _____ Return Date:_____

Please indicate, in the order you will visit them, the countries to which you are traveling. Also indicate length of stay in each country.

Destination (Country, City) Where will you stay? Length of Stay_____

_____

_____

_____

_____

_____

With whom will you be traveling?

_____

_____

Please circle all that apply to your travel plans:

Major Resort Hotels | Cruise Ships | Camping | Rural travel at any time

Staying with a family | Small Hotels | Safari | Outdoor activities

Rented foreign home | Youth hostel | OTHER:_____

What is the purpose of travel? (Please circle)

Business | Student | Vacation | Missionary | Teacher

Volunteer Agency | Field Work | Climbing | Diving | OTHER:_____

Please circle all the travel vaccines you have had:

Typhoid – oral or injectable? | Hepatitis B | Flu Vaccine | Doxycycline

Yellow Fever | Cholera | Meningococcal | Immune Globulin

Polio – oral or injectable? | Rabies | Japanese Encephalitis | Malaria Drug

Measles | Tuberculin Test | Pneumococcal | Mumps

Tetanus Diphtheria | Rubella

Goals of your Travel Medicine service visit:

_____

_____

_____

How did you hear about our services? (Please circle)

Physician Referral | Hospital | Relative/Friend | Internet | Yellow Pages

Did you visit our website, **SafePassageTravelMedicine.com**? **Yes or No**

Will children be traveling with you? Yes or No

If yes, please list their name(s) and date(s) of birth:

_____

_____

_____

Please list the name, address, and phone number of your family physician?

_____

_____