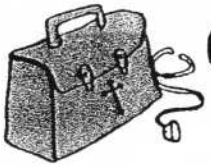


GracePointe Healthcare PLLC

Modern medicine the old fashioned way

PLEASE PRINT AND COMPLETE IN FULL

Date_____

Patient's Legal
Name:_____Nickname_____
Last First M

Sex: Male_____Female_____ Birthdate:_____Age:_____

Patient's Social Security Number:_____

Responsible Party's Name:_____If Patient is a minor, Parent/Guardian's Name_____

Patient's Street Address_____

City/State_____Zip Code_____

Home Phone Number_____Work Phone Number_____Cell Phone Number_____

Email Address_____

Name and Relationship of Emergency Contact (outside the home)_____

Phone Number of Emergency Contact_____

Patient's Marital Status: Married_____Single_____

Spouse / Significant Other's Name_____

How did you learn of our office_____

Reasons for visit (please be specific)_____

_____

How will you pay today? Cash_____Check_____Credit Card_____

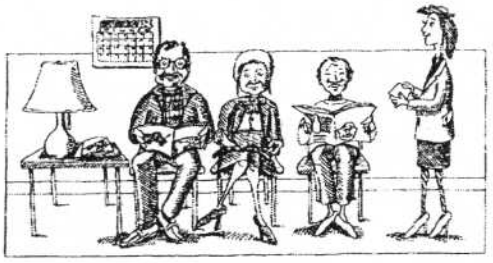
I understand payment in full is due at time of service.

I understand 24 hours notice is required for appointment cancelations and I will be charged a $49 fee if I fail to make my appointment without canceling at least 24 hours in advance.

Patient (or legal guardian) Signature _____

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Item #P4065 (2/08)

Printed by Immunization Action Coalition • Saint Paul, MN • (651) 647-9009 • www.immunize.org/shop

Travel Clinics of America
Dedicated to Safe Travel

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Franklin, TN 37067
615-599-6868
Fax: 615-599-6988

www.TravelClinicsofAmerica.com

TRAVEL MEDICAL HISTORY QUESTIONNAIRE (REV. 08.27.09)

Name *(Last, First,M.I.):*		**Date:**	☐ M ☐ F
Country of Birth:	**Occupation:**		**Date of birth:**
Personal Physician name:	**Address:** **Phone:**		

Have you previously traveled to a developing country? ☐ Yes ☐ No

Are you traveling alone? ☐ Yes ☐ No	**If no, list who you are traveling with and age:**
Departure date:	**Return date:**

Please list in order all countries you plan to visit and the length of stay

1.	**3.**
2.	**4.**

TRIP PURPOSE: check all that apply	ACCOMODATIONS: check all that apply	TRIP ACTIVITIES: check all that apply
☐ Business	☐ Hotel 4 or 5 Star	☐ Air travel
☐ Vacation	☐ Hotel 2 or 3 Star	☐ Public transportation e.g. bus, train
☐ Study	☐ Hostel	☐ Biking
☐ Missionary	☐ Private home	☐ Rental car
☐ Visiting friends or relatives	☐ Camping	☐ Water sports e.g. swimming, boating
☐ Safari	☐ Safari	☐ Scuba or Snorkeling
☐ Cruise	☐ Staying with locals	☐ Climbing or Hiking
☐ Long stay	☐ Long-stay apartment	☐ Visiting schools, hospitals, orphanages
☐ Volunteer or humanitarian work	☐ Cruise ship	☐ Health care worker
		☐ Contact with animals

ALLERGIES

Medication allergy ☐ Yes ☐ No **Which ones?**

Vaccine allergy? ☐ Yes ☐ No

Food allergy? ☐ Yes ☐ No

Environmental allergies e.g. hayfever, bee stings? ☐ Yes ☐ No

Other:

WOMEN ONLY

When was your last period?	**Are you pregnant?** ☐ Yes ☐ No	**If yes, when are you due?**
Are you at risk for pregnancy? ☐ Yes ☐ No	**What is your method of birth control?**	

NAME: **DATE:**

IMMUNIZATION HISTORY

Do you have a written record of your vaccinations? ☐ Yes ☐ No

Have you had any serious reactions to any vaccines? ☐ Yes ☐ No

Vaccines	Date(s) Received	Never had	Not sure	Had disease
Tetanus-Diphtheria Vaccine or Tdap				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series				
Polio-adult booster				
Chicken pox (Varicella) (2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (☐ oral or ☐ injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				

Other vaccines:

MEDICAL HISTORY

Psychiatric problems ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Gastrointestinal problems ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No	Heart disease or surgery ☐ Yes ☐ No	Respiratory problems ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No	Immunity problems ☐ Yes ☐ No	Immune suppression drugs ☐ Yes ☐ No

Other:

Please explain any "yes" answers:

Have you had any surgeries in the past year? ☐ Yes ☐ No What kind?

PLEASE LIST ALL YOUR CURRENT MEDICATIONS, include prescriptions, over-the-counter, supplements and eye drops

Name of medication	Condition or reason for use	Name of medication	Condition or reason for use
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment / administration of vaccines by the physician provider. I understand that payment in full by cash or credit card is due at the time of the visit. Travel Clinics of America, LLC does not bill insurance or any third party payor, including Medicare. A portion of the charges may be reimbursable by insurance.

Traveler/Parent/Guardian signature _____ Date _____

NAME:			DATE:
PHYSICIAN NOTES			
BP:	**P:**	**R:**	**TEMP:**

PRE-TRAVEL COUNSELING: check all that apply

☐ Food and water	☐ Medical care abroad	☐ Personal safety
☐ Traveler's Diarrhea self-treatment	☐ Personal Rx	☐ Accidents
☐ Insect protection incl. Dengue	☐ Altitude Illness	☐ STDs/HIV
☐ Malaria ABCD	☐ Water sports	☐ Alcohol and drug use
☐ Fresh water risks	☐ Climate risks: sun and frostbite	
☐ Rabies avoidance	☐ DVT avoidance	☐ FEVER in returning traveler

TRAVEL INSURANCE	MEDICAL KIT	OTHER SUPPLIES

MEDICATIONS

MEDICATION	COMMON DOSING	RX GIVEN
☐ Azithromax	1000 mg x 1 or 500 mg QD x 3 d for T.D.	
☐ Ciprofloxin	500 mg BID x 3 d for T.D.	
☐ Rifaximin	200 mg QD while traveling	
☐ Diflucan	150 mg once for yeast infection	
☐ Chloroquine	500 mg QW (1-2 wk before, 4 wk after)	
☐ Doxycycline	100 mg QD (1-2 d before, 4 wk after)	
☐ Malarone	250 mg QD (1-2 d before, 7 d after)	
☐ Mefloquine	250 mg QW (1wk before, 4 wk after)	
☐ Ambien	5-10 mg HS	

NAME:						DATE:	
VACCINES							
	Adult CPT / ICD-9	Mfg/lot	Exp. Date	Dose/site	VIS	Refusal sign.	Cost
☐ Td or ☐ Tdap	90714/V06.5 90715/V06.1						
☐ Hepatitis A 1st dose	90632/V05.3						
☐ " 2nd dose	90632/V05.3						
☐ Hepatitis B 1st dose	90746/V05.3						
☐ " 2nd dose	90746/V05.3						
☐ " 3rd dose	90746/V05.3						
☐ Influenza							
☐ IPV	90713/V04.0						
☐ Japanese Encephalitis 1st dose	90738/V05.0						
☐ " 2nd dose	90738/V05.0						
☐ " 3rd dose	90738/V05.0						
☐ Menactra ☐ Menomune	90734/V03.89 90733/V03.89						
☐ MMR	90707/V06.4						
☐ Pneumovax	90732/V03.82						
☐ Rabies 1st dose	90675/V04.5						
☐ " 2nd dose	90675/V04.5						
☐ " 3rd dise	90675/V04.5						
☐ Twinrix 1st dose	90636/V05.3						
☐ " 2nd dose	90636/V05.3						
☐ " 3rd dose	90636/V05.3						
☐ " 4th dose	90636/V05.3						
☐ Typhoid ☐ oral ☐ injectable	90690/V03.1 90691/V03.1						
☐ Varicella	90716/V05.4						
☐ Yellow Fever	90717/V04.4						
☐ Gardasil	90649/V05.8						
☐ Zostavax	90736/V05.8						
☐ PPD	86589/V74.1						
☐ Administrative fee 1 / 2 or more	90471/90472						
☐ Consult							
TOTAL							

Traveler signature _____ Date _____

Physician signature _____ Nurse signature _____