Travel Health of WNC

REGISTRATION FORM

****Please note we do not file insurance for Travel Health****

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Home phone no.( )					
Street address:					
Birth date:	Age:	Social Security no.:			Sex: ☐ M ☐ F
Email:		Language: ☐ English ☐ Spanish ☐ Other:		Ethnicity: ☐ Latino/Hispanic ☐ Other	
Pharmacy:	Employer:		Phone:		
Referred to clinic by:	☐ Doctor ☐ Friend ☐ Family ☐ Web ☐ Other:				
Dates of Departure and Return:	From:	To:	Total Weeks:		
Destination(s):	Country:	Province:	County:	Province:	
Who will travel with you:	Name and date of birth: Name and date of birth:				
Please list any medications you are currently taking:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):			Relationship:		
Home phone no.:			Other phone no.:		

MEDICAL INFORMATION

Do you have allergies to any of the following? ☐ Eggs ☐ Antibiotics ☐ Mercury (thimerosal) ☐ Grasses/mold ☐ Formaldehyde ☐ Other:

Are you being treated for leukemia, lymphoma, cancer or any other malignant disease? ☐ Yes ☐ No
If yes please explain:

Are you taking any steroid drugs? ☐ Yes ☐ No If yes please list medication(s):

Do you have a history of : ☐ deficiency of immune system ☐ anemia or any other blood disorder ☐ Diabetes ☐ Heart Disease ☐ Other:
☐ Psychiatric illness (depression, psychosis, hallucinations or mania)
If any boxes are checked please explain:

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

Have you taken a prophylactic drug for malaria in the past? ☐ Yes ☐ No If so what drug(s)?

Please check and date the vaccinations you have received in the past:

☐ Typhoid (oral or vaccine)	☐ Hepatitis A	☐ Hepatitis B	Flu (2011) ☐ Yes ☐ No
☐ Yellow Fever	☐ Meningococcal	☐ Polio	
☐ Japanese Encephalitis	☐ TB skin test	☐ Pneumococcal	
☐ Td/Tdap	Other:		

I verify that all the information provided on this form is true and correct to the best of my knowledge

Signature_______________________________________ Date____

CONSENT FOR VACCINES AND PRIVACY PRACTICES

(PLEASE DO NOT FILL OUT BELOW THIS LINE UNTIL DATE OF VISIT)

I have read and had explained to me the information about the vaccines I am receiving today. I have had a chance to ask questions which were answered to my satisfaction. I understand the risk and benefits of the vaccines and hereby request that the vaccines be given to me or my child. I understand that one must receive the entire series of any vaccine in order to be protected against disease. ☐ Yes ☐ No

Travel Health of WNC offered to me a copy of its "Notice of Privacy Practices" ☐ Yes ☐ No

Patient/Guardian printed name:	
Patient/Guardian signature:	Date: