Passport Health® Patient Registration

Patient's Name: (Last, First, Middle initial)				Date of Birth:
Address:	City:	State:	Zip:	Primary Phone Number:
Sex: ☐ Male ☐ Female	Email Address:			
Employer Name:	Employer Address:			Work Phone Number:
Person to call in case of Emergency:	Relationship:			Phone Number:

Medical History

What is the name, address, and phone number of your family physician or primary care provider:

Current Medications: (please list, including oral contraceptives, or steroids e.g. Cortisone or prednisone.)

_____
_____
_____

Please list ***ANY*** medication allergies and your reactions:

_____
_____
_____

Are there ***ANY*** other health concerns or issues that we should know about. (Anxiety attacks, fear of needles, claustrophobia, etc.)

_____
_____
_____

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

I have no known allergies ☐

☐ Eggs	☐ Medicine	☐ Antibiotics (esp. Neomycin)	☐ Mercury (thimerosal)
☐ Feathers	☐ Sunlight	☐ Grass or Mold	☐ Formaldehyde
☐ Vaccines	☐ Quinine	☐ Yeast	☐ Insect/ Bee Stings

Are you traveling against medical advice (AMA)?	YES ☐	NO ☐
Are you being treated for leukemia, lymphoma, cancer, or any other malignant disease?	YES ☐	NO ☐
Do you have a history of deficiency of the immune system?	YES ☐	NO ☐
Do you have a history of anemia or any other blood disorder?	YES ☐	NO ☐
Do you have a history of high blood pressure?	YES ☐	NO ☐
Do you have a history of motion sickness?	YES ☐	NO ☐
Do you have eczema or other chronic dermatitis?	YES ☐	NO ☐
If female, are you pregnant, suspect that you may be pregnant, or are trying to become pregnant?	YES ☐	NO ☐
If yes, Date of LMP, or months pregnant?_____		
Do you have ***ANY OTHER medical conditions or history*** we should know about?	YES ☐	NO ☐
If yes, please list:_____		

Please complete the back

Medical History (continued)

Please mark yes or no: Have you:

Had a Tuberculin test or PPD in the past 2 years?	YES ☐	NO ☐
Ever had any reaction to an immunization?	YES ☐	NO ☐
Ever traveled internationally? (other than Canada)	YES ☐	NO ☐
If yes, did you get ill?	YES ☐	NO ☐

What were your symptoms? ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Fever ☐ Infection

Travel Information

Please indicate, **in the order you will visit**, the countries you are traveling to: ***** if more than 3 destinations please bring a COMPLETE list*****

Date of Departure	Destination (City, Country)	Date of return or transfer	Length of stay
First Destination			

Please mark all that apply to your travel plans:
☐ Major Resort Hotels ☐ Cruise Ships ☐ Camping ☐ Rural Travel at any time
☐ Staying with Family ☐ Small Hotels ☐ Safari ☐ Outdoor activities
☐ Rented Foreign Home ☐ Youth Hostel ☐ Other

What is the purpose of your travel? (mark all that apply)
☐ Business ☐ Student ☐ Vacation ☐ Missionary ☐ Teacher ☐ Volunteer Agency
☐ Field Work ☐ Mt.Climbing ☐ Diving ☐ Adoption ☐ Other

Second Destination			

Please mark all that apply to your travel plans:
☐ Major Resort Hotels ☐ Cruise Ships ☐ Camping ☐ Rural Travel at any time
☐ Staying with Family ☐ Small Hotels ☐ Safari ☐ Outdoor activities
☐ Rented Foreign Home ☐ Youth Hostel ☐ Other

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☐ Business ☐ Student ☐ Vacation ☐ Missionary ☐ Teacher ☐ Volunteer Agency
☐ Field Work ☐ Mt.Climbing ☐ Diving ☐ Adoption ☐ Other

Third Destination			

Please mark all that apply to your travel plans:
☐ Major Resort Hotels ☐ Cruise Ships ☐ Camping ☐ Rural Travel at any time
☐ Staying with Family ☐ Small Hotels ☐ Safari ☐ Outdoor activities
☐ Rented Foreign Home ☐ Youth Hostel ☐ Other

What is the purpose of your travel? (mark all that apply)
☐ Business ☐ Student ☐ Vacation ☐ Missionary ☐ Teacher ☐ Volunteer Agency
☐ Field Work ☐ Mt.Climbing ☐ Diving ☐ Adoption ☐ Other

OPTIONAL SURVEY QUESTIONS: Answering the following questions will help us with our research.

How did you hear about our service?
☐ Family/Friend ☐ Doctor's Office ☐ Work ☐ Other_____ (specify)
☐ Travel Agency ☐ Internet

Last grade completed:
☐ Graduate School or Higher ☐ College Graduate ☐ Partial College ☐ High School Graduate
☐ Partial High School ☐ Junior High School ☐ Less than 7 years of school ☐ Preschool

Occupation:
☐ High executive, proprietors of large concerns
☐ Business manager, proprietors of medium sized businesses
☐ Professional (Physician, Nurse, Lawyer, Educator, etc.)
☐ Administrative personnel, small independent businesses
☐ Machine operator and semi-skilled employee
☐ Clerical and sales workers, technician
☐ Skilled manual employee
☐ Unskilled employee
☐ Military service
☐ Retired
☐ Homemaker
☐ Student
☐ Other: _____

The above information is true and accurate to the best of my knowledge. -I give my consent, voluntarily and of my own free will, to the medical staff to provide medical recommendations and care. -I am aware of the URMC and Affiliates Notice of Privacy Practices and know that I can receive a copy of it at the time of my visit or at http://www.urmc.rochester.edu/privacy. -I understand that the risks and benefits of any vaccine or medication will be explained to me in written and verbal form, and I will have all my questions answered prior to receiving any vaccinations. -I waive any claims against the University of Rochester, its officers, directors and employees whether caused by my negligence or the negligence of others. -I also agree to provide my Primary Care Provider with a copy of my immunization(s). -I understand that insurance may not cover for travel health services and that payment is due at the time of services by cash, check, Visa or MasterCard or Discover.

_____ _____
Signature of Patient, Parent or Guardian Date