Travel Patient Information Form

Last Name_____ First Name_____ Age_____
Gender M/F Last Menstrual Period_____ Date of Birth_____
Address_____City_____ State_____Zip ____
Best Phone Number to reach you_____
Email_____
How did you hear about us?_____ Yelp/Google?(please circle all that apply)
Occupation _____ Employer _____
Employer Address: _____
Employer Telephone Number: _____
Date of last Physical Exam _____
Emergency Name & Contact # _____

PCP Name:_____
Address:_____
Telephone:_____
I hereby request and authorize Farragut Medical & Travel Care to release information regarding my visit to my Primary Care Physician listed above: ☐ No ☐ Yes _____
(Initial)

ELECTRONIC MEDICAL RECORD & PRACTICE FUSION CONSENT

We have begun using **Practice Fusion**, a new electronic medical record (**EMR**) that can give you access to parts of your medical record. Please let us know if you would like access to your Patient Fusion portal and we will give you a PIN number as you leave our office.

I would like a PIN to have access to my own patient records
(circle one) **YES** **NO**

Unfortunately at this time we are **not** able to accept online appointments. But please feel free to either email (info@farragutmedical.com) or call our office for any future appointment requests.

Travel Plans

Departure date _____ Return Date _____

Countries to be visited in order ***including Airplane Stops and Layovers***	Length of stay

Reason for Trip: Business/Tourist/Student/Volunteer/Other _____
Will your travel include urban/rural/both?
Will your travel include any overnight backpacking? Y/N
Accommodations: Hotel/Youth Hostel/Private Home/Camping/Tent/Cruise/Other

Medical Problems/Illness/Injury

Please circle if you have had/have any of the following:

Mental Illness/Depression
Seizure disorder
High blood pressure
Diabetes
Ulcers
Heart trouble
Chest pain
Heart murmur
Stroke
Cancer
Hepatitis
Gallstones
Kidney stones
GI bleeding
Diverticulosis
Thyroid problems
Lung disease/asthma
Shortness of breath
Accidents/broken bones
Skin disease
Bleeding disorder/anticoagulants
Other:

List any hospitalizations or surgeries:

_____

Current Medications (list): include over the counter

_____
_____
_____
_____

Allergies: _____

_____
_____
_____
_____

Are you allergic specifically to? Bee stings/Eggs/Thimerosal/Latex/Gelatin/Sulfa/Streptomycin

PLEASE ANSWER ALL	YES x	NO x
Are you Pregnant or trying to get Pregnant?		
Are you nursing?		
Have you ever had an adverse reaction to a shot?		
Do you have a immune disorder (i.e. immunosuppressive medication, chemotherapy, cancer or HIV)		
Do you LIVE WITH someone who has HIV, cancer, or is taking Prednisone, steroids or chemotherapy?		

Immunization History

Vaccine	Year	Vaccine	Year
Hepatitis A Vaccine		Rabies	
Hepatitis B Vaccine		Tetanus	
Immune Globulin		Typhoid	
Influenza		Varicella (chickenpox)	
Japanese E		Yellow Fever	
MMR		Herpes Zoster	
Meningitis		Gardisil	
Polio		Pneumococcal	

I understand that I will be charged a consultation fee for today's visit of $50 in addition to the cost of each vaccine. If vaccines are not administered, the office fee is $120. I am aware that all fees are due at the time services are rendered, unless other arrangements have been made in advance.

The above information is true and accurate.

Patient signature: _____Date: _____/_____/_____