

Travel Patient Information

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 Contact Name (relationship) and Phone _____

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**

Travel Plans

Departure date _____ **Return Date** _____

| <i>Countries</i> to be visited in order <i>including Airplane Stops and Layovers</i> | Length of stay (# of Days) |
|--|----------------------------|
| | |
| | |
| | |
| | |
| | |

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

List any hospitalizations or surgeries:

| | |
|--|------------|
| Current Medications w/Dosage: 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 | | Gardasil | |
| Polio | | Pneumococcal | |

I understand that I will be charged a consultation fee for today's visit of \$55 in addition to the cost of each vaccine. If vaccines are not administered, the office fee is \$130. I am aware that all fees are due at the time services are rendered, unless other arrangements have been made in advance. We do not participate with any insurance nor guarantee reimbursement for services rendered in our office. As a courtesy, we are happy to submit a form to your insurance company so that you may seek reimbursement for the services you receive today. If you would like us to do so, please give the receptionist your insurance card.

The above information is true and accurate.

Patient signature: _____ Date: ____/____/____