Travel Consult / Vaccination Visit

Please Print

Last Name, First, Middle initial | Date of Birth | Daytime Phone Number

Address | City | State | Zip Code

E-mail Address | Pharmacy Name and Address

Race:

☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other:_____

Have you ever been to our clinic before?_____

Trip Information:

Date of Departure: _____ Return Date: _____

Itinerary – List ALL countries with state/city in order of travel (including layovers) outside the USA:

Prior Immunizations (Year Given):

Hepatitis A (Series of 2) _____

Hepatitis B (Series of 3) _____

Polio Booster _____

Tetanus / Diphtheria (TD / TDaP) _____

Tuberculosis Skin Test (PPD) _____Positive/Negative

Yellow Fever _____

Japanese Encephalitis

Rabies (Pre or Post Exposure)

Meningitis

Typhoid (Oral / Injection)

*** Please list any adverse reactions to immunizations/injections (i.e. fainting):_____**

Allergies (Medications, Foods, Seasonal, Environmental**):**

Medical History (Have you had or currently have any of the following? If so, please explain)

Arthritis No ___ Yes ___ _____

Asthma No ___ Yes ___ _____

Blood Thinners	No ___	Yes ___	_____
Depression / Anxiety / Panic Attacks	No ___	Yes ___	_____
Diabetes	No ___	Yes ___	_____
Eczema or Psoriasis	No ___	Yes ___	_____
Heart Disease / Pacemaker	No ___	Yes ___	_____
High Blood Pressure	No ___	Yes ___	_____
Hepatitis	No ___	Yes ___	_____
Muscle or Bone Disease	No ___	Yes ___	_____
Nervous System Disorder	No ___	Yes ___	_____
Renal (Kidney) Disease	No ___	Yes ___	_____
Respiratory Disease (COPD/emphysema/bronchitis)	No ___	Yes ___	_____
Seizures / Convulsions	No ___	Yes ___	_____
Sickle Cell Anemia	No ___	Yes ___	_____
Stomach Ulcers / Heartburn / Reflux	No ___	Yes ___	_____
Thyroid Disease	No ___	Yes ___	_____
Tuberculosis	No ___	Yes ___	_____
Thymus Gland Disorder (Myasthenia Gravis or DiGeorge Syndrome)	No ___	Yes ___	_____
Immune Disorder (Chemotherapy, HIV, bone Marrow or Organ Transplant, Rheumatoid Arthritis)	No ___	Yes ___	_____
Surgery or Hospitalization in Past 3 Years	No ___	Yes ___	_____

Other _____

Do You Smoke? No ___ Yes ___ Packs Per Day _____

Medications: ***Please list ALL current – prescriptions and Over -The –Counter vitamins/supplements***

_____
_____
_____
_____

How did you hear about our clinic?

_____

Thank you for choosing Great Lakes Physician Services for your travel/ immunization needs. At your visit, our provider will discuss with you the vaccinations that you are interested in. If you are traveling abroad, our providers will supply you with all the information you need to help you stay healthy during your trip.

Please be aware that we DO NOT participate with any insurance companies and do not take it as a form of payment. Once you meet with our provider and determine which immunizations you will be receiving today, you will be expected to pay for those immunizations along with a $50.00 office visit fee (for up to 3 people, 4 or more is $60.00). If you need to return to complete a series of shots (i.e. Hepatitis B, you will only be charged one office visit fee). We accept Cash, Visa, or MasterCard as methods of payment. At the time of payment, itemized

receipts will be provided for insurance submission purposes. We cannot guarantee that your insurance provider will reimburse any of your costs for these services. The amount reimbursed to you, if any, is dependent upon the terms of your insurance plan.

By signing below, you are indicating that you have read and understand the above payment policy:

_____ _____ _____

Print Name **Signature** **Date**