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 ______________

Countries to be visited in order *including Airplane Stops and Layovers*	Length of stay (# of Days)

Reason for Trip: Business/Tourist/Student/Volunteer/Other _________________________
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 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 $60 in addition to the cost of each vaccine. If vaccines are not administered, the office fee is $135. 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.

Are you a MEDICARE participant? Yes No

The above information is true and accurate.

Patient signature: ____________________________Date: _____/_____/______