



## Occupational Health Services Patient Information Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_ Email \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_

Travel Departure Date \_\_\_\_\_ Return Date \_\_\_\_\_

Countries to be visited (in order)	Length of Stay

Reason for trip: Business Tourist Student Mission Other \_\_\_\_\_

Are you planning to travel outside of urban areas? Yes No

Are you planning to go hiking, backpacking or swimming? Yes No

Accommodations: Hotel Youth Hostel Private Home Camping Cruise Other \_\_\_\_\_

Do you have:

- |                                                               |     |    |
|---------------------------------------------------------------|-----|----|
| Heart trouble/High Blood Pressure .....                       | Yes | No |
| Lung Disease/Asthma .....                                     | Yes | No |
| Diabetes .....                                                | Yes | No |
| Skin Disease .....                                            | Yes | No |
| Mental Illness/Depression .....                               | Yes | No |
| Seizure disorder/Epilepsy .....                               | Yes | No |
| A bleeding disorder and/or take anticoagulants? .....         | Yes | No |
| A history of thymus condition/thymectomy? .....               | Yes | No |
| A history of an immune disorder, such as cancer or HIV? ..... | Yes | No |

Have you received any vaccine within the last 30 days (chickenpox/shingles/MMR)? Yes No

Have you ever had an adverse reaction to a shot? Describe \_\_\_\_\_ Yes No

Have you taken Prednisone, steroids, or chemotherapy drugs in the last 3 months? Yes No

Do you LIVE WITH someone who is taking Prednisone, steroids, or chemotherapy drugs? Yes No

Do you LIVE WITH someone who has cancer or HIV? Yes No

Do you plan to have medical/dental procedures overseas? Yes No

Do you take blood thinners? Yes No

CIRCLE any allergies you may have: eggs latex yeast mercury(Thimerisal) gelatin bee stings

Medicine allergies (list) \_\_\_\_\_ other allergy(list) \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

When was your last tetanus shot? \_\_\_\_\_

<b>Women Only:</b>	
Are you pregnant or trying to get pregnant?	Yes No
Are you breastfeeding?	Yes No
Last Menstrual Period _____	

**PLEASE PRESENT A COPY OF YOUR IMMUNIZATION RECORDS**

**Consent for Services:** I understand that, while remarkably safe, vaccines can, in rare instances, cause complications including death. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease.

I also understand that CVMC OHS does not file claims for nor accept any form of insurance payment for travel visits. I understand that my health insurance is a contract between me and my insurance company. I understand that CVMC OHS will not refund any difference between my insurance reimbursement and CVMC OHS charges.

**I certify that the above information is correct**

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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