CENTER FOR TRAVEL MEDICINE
www.centerfortravelmedicine.com

Nicholas S. Camps, DO / Cynthia I. Rivera, MD / Claudio D. Tuda, MD
4308 Alton Road, Suite #860, Miami Beach, Florida 33140-2891
(305) 674-2766 tele
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New Patient Questionnaire

Last Name, First Name, Middle Initial:		Date:
Date of Birth:	Age:	Gender at Birth: □ Female □ Male

Address:

Address Line 2:

City, State and Zip Code

Phone Number(s) *Check box representing preferred number for patient reminders, etc.* □ Home □ Cell □ Work

Occupation:

How did you hear about us?	Will this be your first visit at our facility? Yes □ No □

Travel Destination	Date of Departure	Length of Stay

What is the reason of your travel (please be as specific as possible)? _____

History of travel related illness? Yes □ No □
If yes, please explain: _____

Are you under the care of a physician? Yes □ No □
If yes, please explain: _____

Are you taking any medication(s)? Yes □ No □
If yes, please list: _____

Do you have any allergies? Yes □ No □
If yes, please list: _____

Have you had any previous reactions to any of the following:

Eggs	Yes □	No □	Don't know □	Doxycycline	Yes □	No □	Don't know □
Neomycin	Yes □	No □	Don't know □	Sulfa Drugs (example, Bactrim)	Yes □	No □	Don't know □
Immunization*	Yes □	No □	Don't know □	**If yes, please specify*:**			

Are you on therapy with ACTH, Corticosteroids, Radiation or Immunosuppressing medication? Yes □ No □

If other, state name: _____

Do you have any blood disease, leukemia, lymphomas, malignant neoplasm, HIV infection or AIDS? Yes □ No □

Are you pregnant, suspect to be pregnant or trying to become pregnant? Yes □ No □ Not Applicable □

Have you been hospitalized for a medical or surgical reason in the last 6 months? Yes □ No □

If yes, please explain: _____

Do you have a cold or fever now or had one within the past two weeks? Yes □ No □

Have you received any injections within the past two weeks (diphtheria, tetanus, measles, etc.) Yes □ No □

Have you ever had GBS (a form of paralysis)? Yes □ No □

Vaccination History

Have you ever had any of the following vaccinations/malaria tablets and if so when?

Vaccine	Yes	No	Date	Vaccine	Yes	No	Date
Diphtheria				Polio			
Hepatitis A				Rabies			
Hepatitis B				Tetanus			
Influenza				Tick Borne			
Japanese Encephalitis				Typhoid			
Meningitis				Varicella			
Pneumococcal				Yellow Fever			
Other:							

Patient's Name:	**Date:**
Patient's/ Guardian's Signature:	□ **Self or Relationship to Patient**

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PATIENT VACCINATION CONSENT

All vaccines may cause side effects and/or adverse reactions. Such side-effects/adverse reactions may include:

- Redness, warmth, pain, swelling or itching at the injection site.
- Generalized urticaria (swelling, itchy rash); painful joints; swollen red joints; generalized swelling; rash; headache, nausea; abdominal pain; muscle aches; dizziness; transient fever.
- Rarely, anaphylactic shock or Guillian-Barre Syndrome. Death may result from either of these reactions.
- Oral Polio Vaccine: Paralytic polio has occurred in persons receiving the vaccine (1case/8.7 million OPV doses distributed).

SPECIAL PRECAUTIONS:

Children under the age of three years and pregnant women should consult with their personal physicians before receiving any vaccine.

Persons who are allergic to eggs, chickens, chicken feathers, or chicken dander should not receive certain vaccines prepared from egg.

Persons with fever or any acute or serious illness should not receive vaccines.

Persons who are immunocompromised either as a result of illness or medication (ex: cancer, chemotherapy, radiation therapy, AIDS, corticosteroids, etc.) should consult with their private physician prior to being immunized.

PLEASE INFORM THE PERSON GIVING THE VACCINE IF THERE IS ANY POSSIBILITY OF YOUR BECOMING PREGNANT WITHIN THE NEXT THREE MONTHS.

I have read the above information and have had the opportunity to ask questions regarding the risks and benefits of the vaccines recommended. I consent to have the vaccines given to me or to the person named below for whom I am the Legal Representative for with the right to make healthcare decision.

Patient's Name:	**Date:**
Patient's/ Guardian's Signature:	□ **Self or Relationship to Patient**

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient's Name:	**Date:**
Patient's/ Guardian's Signature:	□ **Self or Relationship to Patient**