

# THE TRAVEL CLINIC 1200 Hilyard St., Suite 560, Eugene OR USA 541.343.6028

name \_\_\_\_\_ home phone \_\_\_\_\_ today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

address (not post office box) \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

mailing address (like PO Box) \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

work phone \_\_\_\_\_ email address \_\_\_\_\_ your birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

who told you about us? \_\_\_\_\_ name of your medical insurance \_\_\_\_\_

\*\*\*\*\* Please take the time to make this information **complete** and **accurate** \*\*\*\*\*  
 \*\*\*\*\* since it will determine what kind of disease protection you need. \*\*\*\*\*

departure date \_\_\_\_/\_\_\_\_/\_\_\_\_

return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**countries you plan to visit (please list in sequence):**

country	urban	rural	for how long?	purpose of your visit (what you will be doing)
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

\*\*\*\*\*

**prior immunizations:**

	received vaccine before?				last booster?	
	yes	prob- ably	no	don't know	approx. date	don't know
yellow fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
oral polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
injectable polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
measles or MMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
oral typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
injectable typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
tetanus-diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
japanese encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
pneumococcal pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
rabies vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
hepatitis A VACCINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>

(hepatitis A vaccine has been available only since April, 1995)

influenza vaccine last dose \_\_\_\_\_

\*\*\*\*\*

Check if you have had these diseases:    measles     hepatitis A     chicken pox

Who is your regular doctor? \_\_\_\_\_

A report of the vaccines you receive will be sent to your doctor unless you do not approve.

**PLEASE COMPLETE BOTH PAGES OF THIS FORM**

Please initial either 1 or 2, but not both:

1. \_\_\_\_ I give permission to Dr. Wilson to correspond with me about my itinerary, prior immunization record, general medical history, medications and his recommendations by email using any of the contact information I have given him. Dr. Wilson is given this permission for an indefinite period of time.

- OR -

2. \_\_\_\_ I do not give permission to Dr. Wilson to use email for the above information. I will inform Dr. Wilson which items may be discussed by email.

**MEDICAL HISTORY (please check if true):**

- I was raised outside of the USA.
- I am not sure I received all childhood vaccines.
- I have had allergic reaction to eggs (can't eat eggs).
- I am allergic to thimerosal (a mercury derivative).
- I have fainted after shots or drawing blood.
- I have had an allergic reaction to any vaccine.
- My spleen or thymus has been removed.
- I am taking antibiotics now.
- I have taken cortisone/steroids in the past 3 months.
  
- I am pregnant now, or may be pregnant now, or may become pregnant before or during my trip.

**I have or have had these medical problems:**

- |   |  |
|---|--|
| <input type="checkbox"/> diabetes             | <input type="checkbox"/> bowel disease       |
| <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> kidney disease      |
| <input type="checkbox"/> seizures             | <input type="checkbox"/> lung disease        |
| <input type="checkbox"/> psychosis            | <input type="checkbox"/> liver disease       |
| <input type="checkbox"/> heart rhythm problem | <input type="checkbox"/> heart disease       |
| <input type="checkbox"/> prostate problem     | <input type="checkbox"/> asthma              |
| <input type="checkbox"/> cancer               | <input type="checkbox"/> ulcers              |
| <input type="checkbox"/> lymphoma             | <input type="checkbox"/> cancer chemotherapy |
| <input type="checkbox"/> radiation therapy    | <input type="checkbox"/> immune deficiency   |

I am allergic to these medicines: \_\_\_\_\_

Please list your current medicines:

\_\_\_\_\_  
\_\_\_\_\_

The above information is complete and accurate. I request and consent to the administration of the vaccines to myself (or to the patient if I am the parent or guardian) agreed upon by myself and Dr. Wilson.

I understand that deposit payment is due at the time services are delivered. I am financially responsible for charges for services rendered to me by John D. Wilson, M.D. LLC (dba The Travel Clinic). I request that payment of insurance benefits be made on my behalf to Dr. Wilson for any services furnished to me. I authorize any holder of medical or other information to release to my insurance provider any information needed to determine benefits under my insurance plan. I authorize my insurance provider to make payment directly to Dr. Wilson. I understand that Dr. Wilson will, as a courtesy, bill my insurance provider on my behalf. I agree to pay Dr. Wilson the difference between the approved charge (as determined by my insurance company) and the amount my insurance company pays to Dr. Wilson according to the agreement I have with my insurance provider. If my insurance pays on a given item, I understand that I may be eligible for a refund of the deposit for that item. I understand that there will be a charge for missed appointments not cancelled within 24 hours. *If my insurance is managed care insurance, and no referral is in place, I understand that I am accepting financial responsibility in signing this waiver.* I understand that if I fail to pay in full on time, I agree to reimburse Dr. Wilson for all costs of collection, including reasonable attorney fees and costs, and to pay interest at the statutory rate.

**Please see our Financial Policy which will clarify some of these issues.**

\_\_\_\_\_  
(signature of traveler and parent/guardian)

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(date)

**PLEASE COMPLETE BOTH PAGES OF THIS FORM**