New York Center for Travel and Tropical Medicine
110 East 55th Street, 16th Floor
New York, NY 10022
Phone: (212) 734 - 3000

TRAVEL QUESTIONNAIRE

NAME__________________________________ **DATE**_________________________________

For Internal Use Only

☐ $85 Pre-Travel Consult, per trip

☐ $35 International Certificate of Vaccination (ICV)

☐ $35 Phlebotomy (Blood Draw)

☐ $35 Vaccination administration fee

PRICE PER DOSE

☐ $90 Polio (IPV)

☐ $255 Shingrix (series of 2 at $255 each; ***$510 TOTAL***)

☐ $85 Tetanus/Diphtheria/Pertussis (TDAP)

☐ $95 Typhoid: Typhim Vi

☐ $105 Hepatitis A (series of 2 at $105 *each*)

☐ $95 Hepatitis B (series of 3 or 4 at $95 *each*)

☐ $155 Hepatitis A&B combination (Twinrix) (series of 3 or 4 at $155 *each*)

☐ $195 Yellow Fever

☐ $165 Meningococcal (Menveo)

☐ $335 Rabies (pre-exposure series of 3 doses at $335 *each;* ***$1,005 TOTAL)***

☐ $325 Japanese Encephalitis (series of 2 doses at $325 *each;* ***$650 TOTAL***)

☐ $210 Pneumococcal (Prevnar-13 or Pneumovax)

☐ $75 Influenza, quadrivalent, trivalent or high dose

☐ $285 Vaxchora (Oral cholera vaccine; patients must be fasting for at least one hour prior to administration of Cholera vaccine)

☐ $125 MMR (Measles, Mumps, Rubella)

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THIS FEE SCHEDULE AND I WILL BE GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

Signature ____

Patient Information

☐ I am a returning patient

Name_______________________________ _______________________________ _____________________________

Last *First* *Middle Initial*

Address ____ ____________________

Number, Street *Apt #*

_______________________________ _______________________________ ____________________________

City *State* *Zip Code*

Telephone:

Cell_____________________________ Home___________________________ Work ______________________________

Email Address ____

☐ Male ☐ Female Date of Birth _______________________________ Age _____________________________

Pharmacy Information: ____

(Name & Phone Number)

Emergency Contact:

Name ____ Relationship to patient____________________________

Phone # ___________________________

Referred By:

☐ Friend ☐ Internet ☐ Another Physician ☐ Other: _________________________

Referring Physician's Full Name

____ ____

First Name *Last Name*

Address ____ _______________________

Number, Street *Apt/Suite/Floor #*

____________________________________ _______________________________ ________________________

City *State* *Zip Code*

Health History

Current Prescriptions, Over-The-Counter Medications and Herbal Supplements

Medication	Reason for use / medical condition

Pertinent Medical and Surgical History

____

Allergies (check all that apply)

☐ NONE

☐ Antibiotics (please specify____

☐ Other medications ☐ Eggs

☐ Latex ☐ Gelatin ☐ Yeast

☐ Bees / wasps ☐ Seasonal ☐ Other ________________

☐ Side effects/ reactions from previous medications (name mediations):

____

Health History (check all that apply)

☐ I do not have any issues with my health

☐ Steroids by mouth within last 3 months ☐ Spleen removed

☐ Immune suppressive medications or treatments within past year

☐ Thymus disease, thymectomy or Myasthenia Gravis ☐ Organ, bone marrow, stem cell transplant

☐ HIV/AIDS

☐ Other (please specify)

____

____

Kidney, Neurologic/psychiatric or OG/GYN Conditions (check all that apply)

☐ Kidney insufficiency ☐ Anxiety / depression ☐ Pregnant?

☐ Seizures or epilepsy ☐ History of Guillain-Barre ☐ Planning to become pregnant?

☐ NONE OF THE ABOVE

Please bring all vaccination records to your appointment

Travel Details

☐ I am not traveling

Purpose of Trip (Check all that apply)

☐ Vacation ☐ Education/Research ☐ Visit friends or family ☐ Volunteer/Relief Work

☐ Work (Urban, office-based) ☐ Work (rural, outdoors or in local community ☐ Relocation

☐ Other: ____

Planned Activities: ____

Will you be:

- Visiting areas that are:
  ☐ Rural ☐ Urban ☐ Primitive or remote
- Ascending to high altitudes (8,000 ft. or higher?) ☐ Yes ☐ No
- Working with potential exposure to bodily fluids (e.g., medical or dental work?) ☐ Yes ☐ No
- Work with exposure to animals? ☐ Yes ☐ No

Accommodations (check all that apply)

☐ Resort / large hotel ☐ Small hotel / guest house ☐ Cruise ship

☐ Private home (with locals) ☐ Private home (with relatives) ☐ Primitive camping

☐ Up-scale camp/lodge ☐ Dormitory/hostel ☐ Other _____________________

Dates	City and Country	# Days in each location

TRAVEL HEALTH MEDICAL, P.C.
110 East 55th Street, 16th Floor
New York, NY 10022

HIPAA AUTHORIZATION FORM

If you want your vaccine records sent to your primary care physician, please complete this section

____
Patient's Full Name

____ ____________________________________
Address **Patient's Date of Birth**

____ ____________________________________
City, State Zip Code **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   The New York Center for Travel and Tropical Medicine

   The following person or class of persons (**IF DIFFERENT FROM REFERRING PHYSICIAN**) may receive disclosure of protected health information about me:

   ____
   Physician/Individual/Entity name

   ____
   Address

   ____
   City, State, Zip Code

   ____
   Phone Number **Fax Number**

2. The specific information that should be disclosed is (please give dates of service if possible):

   ____

   ____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying ________________________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for ____ .
6. This authorization expires on _____________, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: ______________________________________.

______________________________	________________________	____________________________
Signature of Individual* (The person about whom the information relates)	**Date**	**Date of Birth**

OR, if applicable –

______________________________	________________________	____________________________
Signature of Guardian* or Personal Representative of Patient's Estate	**Date**	**Description of Authority to Act for the Individual**