TRAVEL QUESTIONNAIRE

NAME________________________________ DATE______________________________________

For Internal Use Only

☐ $65  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
☐ $95  Hepatitis A (series of 2 at $95 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)
☐ $325 Rabies (pre-exposure series of 3 doses at $325 each; $975 TOTAL)
☐ $315 Japanese Encephalitis (series of 2 doses at $315 each; $630 TOTAL)
☐ $185 Pneumococcal: Pneumovax or Prevnar-13
☐ $75  Influenza, quadrivalent, trivalent or high dose
☐ $265 Vaxchora (Oral cholera vaccine; patients must be fasting for at least one hour prior to administration of Cholera vaccine)

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

Referred by________________________________________

☐ 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

____________________________________________________

Emergency Contact _______________________________ Relationship to patient________________

Phone # _________________________

* If you want a follow-up letter sent to your primary care physician/referring doctor, complete this section*

☐ I do not wish to have a report sent to my physician OR I do not have a physician

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

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<thead>
<tr>
<th>Medication</th>
<th>Reason for use / medical condition</th>
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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 medications):

___________________________________________________________________________________________

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 and OG/GYN Conditions (check all that apply)

☐ Kidney insufficiency

☐ Anxiety / depression

☐ Pregnant?

☐ Seizures or epilepsy

☐ History of Guillain-Barre

☐ Planning to become pregnant?
**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 ___________________

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<thead>
<tr>
<th>Dates</th>
<th>City and Country</th>
<th># Days in each location</th>
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**HIPAA AUTHORIZATION FORM**

<table>
<thead>
<tr>
<th>Patient’s Full Name</th>
<th>Patient’s Date of Birth</th>
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<th>Address</th>
<th>City, State Zip Code</th>
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**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) may receive disclosure of protected health information about me:

<table>
<thead>
<tr>
<th>Physician/Individual/Entity name</th>
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<th>Phone Number</th>
<th>Fax Number</th>
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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 _____________, 200___, 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: ________________________________________.

<table>
<thead>
<tr>
<th>Signature of Individual*</th>
<th>Date of Individual’s Signature</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>(The person about whom the information relates)</td>
<td>OR, if applicable –</td>
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<tr>
<th>Signature of Guardian* or Personal Representative of Patient’s Estate</th>
<th>Date of Guardian’s/Personal Representative’s Signature</th>
<th>Description of Authority to Act for the Individual</th>
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