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

☐	$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

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 and OG/GYN Conditions (check all that apply)

☐ Kidney insufficiency ☐ Anxiety / depression ☐ Pregnant?

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

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

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) 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 _____, 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: _____.

_____ | _____ | _____
Signature of Individual* (The person about whom the information relates) | **Date of Individual's Signature** | **Date of Birth**

OR, if applicable –

_____ | _____ | _____
Signature of Guardian* or Personal Representative of Patient's Estate | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**