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)

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for use / medical condition</th>
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**Pertinent Medical and Surgical History**

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**Allergies** (check all that apply)

- NONE
- Antibiotics (please specify)
- Other medications
- Latex
- Gelatin
- Yeast
- Bees / wasps
- Seasonal
- Other ___________________

- Side effects/ reactions from previous medications (name medications):
  ____________________________________________

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**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)

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**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

Patient’s Full Name

Address

City, State Zip Code

Patient’s Date of Birth

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:

   ____________________________

   ____________________________

   ____________________________

   ____________________________

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*  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