



JENNIFER'S TRAVEL CLINIC
DBA JENNIFER M. LEE FNP, LLC
321 N. KUAKINI ST. #503
HONOLULU, HI 96817
808-546-9023

Today's Date _____

PATIENT'S PERSONAL INFORMATION

Name _____ Date of Birth _____ Age _____ Gender Male Female
(Last, First & Middle Initial)

Mailing Address _____
Street City State Zip Code

Home Address, if different than mailing address:

Home Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ E-Mail Address _____

A copy of your visit will be faxed to your Physician.

Physician's Name _____ Telephone Number _____

Physician's Address _____
Street City State Zip Code

RACE AND ETHNICITY

Race: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Other _____ |

Is English your primary language?

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other _____ |

EMPLOYER / SCHOOL INFORMATION

Name of Employer or School _____ Patient's Occupation _____

Work/School Address _____
Street City State Zip Code

EMERGENCY INFORMATION

Notify In Emergency _____
(Last, First & Middle Initial)

Mailing Address _____
Street City State Zip Code

Home Telephone _____ Cell Phone _____ Relationship to the Patient _____



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INSURANCE COVERAGE

Does Patient have Medicare? Yes No Medicaid? Yes No Medicaid ID # _____

INSURANCE #1	INSURANCE #2
Subscriber Name (Last, Name, M.I.)	Subscriber Name (Last, Name, M.I.)
Date of Birth	Date of Birth
Employer	Employer
Insurance Company	Insurance Company
Policy Number	Policy Number
Group Number	Group Number

**IF SOMEONE OTHER THAN THE PATIENT WILL BE RESPONSIBLE FOR PAYMENT
PLEASE FILL IN THE FOLLOWING**

Name _____
 (Last, First & Middle Initial)

Mailing Address _____
 Street City State Zip Code

Home Phone _____ Cell Phone _____ Social Security No _____

Name of Employer _____ Payer's Occupation _____

Employer's Address _____
 Street City State Zip Code

PURPOSE OF VISIT

What is the purpose of your visit?

Immunization for Travel

OR

Routine Vaccination (Skip TRAVEL SPECIFICS section and **Go to HEALTH HISTORY** section)



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TRAVEL SPECIFICS

Travel Plans:

Purpose of Trip School Related Study/Work Pleasure Business Other _____

What will you be doing on this trip? _____

Does your program require the completion of a medical form by a practitioner? Yes No

Are you currently enrolled in a health insurance plan that covers you while overseas? Yes No

What insurance coverage do you currently have that covers you while overseas? _____

Would you like information on travel insurance? Yes No

Departure date from United States _____ Return date to United States _____

Countries AND cities to be visited in order of visits	Arrival Date	Departure Date

Have you traveled outside the United States before? Yes No

Will you be

Visiting **ONLY** urban areas? Yes No

If no, explain: _____

Staying **ONLY** in Hotels? Yes No

If no, explain: _____

Visiting friend and family? Yes No

Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains? Yes No



HEALTH HISTORY

Medical History

1. Are you using steroids, receiving radiation or other immunosuppressive chemotherapy? Yes No

2. Have you been told you have any of the following medical conditions (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> G6PD Deficiency | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psoriasis/Other Skin Problem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Ear Infections (Chronic) | <input type="checkbox"/> Hormone Problems | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Immune System Deficiency | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | |

Other _____

List your current prescription medications and reason for use (include birth control pills).
 (Please use the back of this form, if you need more space to write your prescriptions)

Current Prescription Medications with Dosage	Condition or Reason for Use
1.	
2.	
3.	
4.	
5.	

List regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc)

Current Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	
4.	
5.	

For Women Only

Date of last menstrual period: _____ Are you or could you possibly be pregnant? Yes No
 Are you currently breast-feeding? Yes No

Smoking

1. Do you currently smoke? Yes No
 If yes, how many packs per day? _____



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Allergies

1. Have you had an allergic reaction to any of the following? What type of reaction(s)? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Quinines (Chlorowuine (Aralen), Mefloquine (Lariam)) |
| <input type="checkbox"/> Seafood (Shrimp, Crab, Lobster) | <input type="checkbox"/> Hydroxychloroquine (Plaquenil, Primaquine) |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Antibiotics (PCN, Ciproflaxin) |
| <input type="checkbox"/> Chrysanthemums (herb) | <input type="checkbox"/> Thimerosal (preservative in contact lens solution) |
| <input type="checkbox"/> Sulfa Drugs (Bactrim, Septra) | <input type="checkbox"/> Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin) |
| <input type="checkbox"/> Pyrimethamine (antiparasitic drug) | |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> No Known drug or food allergies | |

Past Immunizations

1. Were you born in the United States? Yes No If no, where? _____

2. **HAVE YOU RECENTLY RECEIVED A LIVE VACCINATION?** Yes No
If yes, which vaccination? _____

When? _____

3. Have you completed the following immunizations?

- | | | | | |
|--------------------------------------|------------------------------|------------|-----------------------------|-----------------------------------|
| Hepatitis A Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Hepatitis B Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Hepatitis A & B (Twinrix) Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| HPV (Human Papilloma Virus) Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Influenza (for current season) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Japanese Encephalitis 2 dose | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Meningococcal Meningitis | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| MMR (Measles, Mumps, Rubella) 2 dose | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Polio Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Pneumococcal (Pneumonia) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |



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Have you completed the following immunizations? (Continued from previous page.)

- | | | | | |
|--------------------------------------|------------------------------|------------|-----------------------------|-----------------------------------|
| Rabies Series | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Tetanus Diphtheria (TD) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Tetanus Diphtheris Pertussis (Tdap) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Typhoid (Oral or Injectable) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Varicella (or history of chickenpox) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Yellow Fever | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Zoster (Shingles) | <input type="checkbox"/> Yes | When _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |

Questions/Concerns:

How did you hear about us? Personal Physician Internet Travel Agent Other _____

Please provide the referral's name and address, so we may send a Thank You note _____

***Thank you for choosing Jennifer's Travel Clinic!
We appreciate your business & humbly ask for your continuing support.***