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

Today's Date _____

Instructions:
Please fill out this form as completely as possible. Because it is lengthy, we recommend that you save the file often and keep a copy for your records. If you wish to print the file, you may also do that for your records. When you have completed this form, please email us a digital copy.

Mahalo!
Jennfer's Travel Clinic Staff

PATIENT'S PERSONAL INFORMATION

Last, First 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)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Other _____

Is English your primary language?

- ☐ Yes
- ☐ Unknown
- ☐ No
- ☐ 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

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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)?

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

☐ 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)

- ☐ Eggs
- ☐ Seafood (Shrimp, Crab, Lobster)
- ☐ Latex
- ☐ Chrysanthemums (herb)
- ☐ Sulfa Drugs (Bactrim, Septra)
- ☐ Pyrimethamine (antiparasitic drug)
- ☐ Quinines (Chlorowuine (Aralen), Mefloquine (Lariam)
- ☐ Hydroxychloroquine (Plaquenil, Primaquine)
- ☐ Antibiotics (PCN, Ciproflaxin)
- ☐ Thimerosal (preservative in contact lens solution)
- ☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin)
- ☐ Other: _____

☐ **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	☐ Yes	When _____	☐ No	☐ Not Sure
Hepatitis B Series	☐ Yes	When _____	☐ No	☐ Not Sure
Hepatitis A & B (Twinrix) Series	☐ Yes	When _____	☐ No	☐ Not Sure
HPV (Human Papilloma Virus) Series	☐ Yes	When _____	☐ No	☐ Not Sure
Influenza (for current season)	☐ Yes	When _____	☐ No	☐ Not Sure
Japanese Encephalitis 2 dose	☐ Yes	When _____	☐ No	☐ Not Sure
Meningococcal Meningitis	☐ Yes	When _____	☐ No	☐ Not Sure
MMR (Measles, Mumps, Rubella) 2 dose	☐ Yes	When _____	☐ No	☐ Not Sure
Polio Series	☐ Yes	When _____	☐ No	☐ Not Sure
Pneumococcal (Pneumonia)	☐ Yes	When _____	☐ No	☐ Not Sure

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

Rabies Series	☐ Yes	When	☐ No	☐ Not Sure
Tetanus Diphtheria (TD)	☐ Yes	When	☐ No	☐ Not Sure
Tetanus Diphtheris Pertussis (Tdap)	☐ Yes	When	☐ No	☐ Not Sure
Typhoid (Oral or Injectable)	☐ Yes	When	☐ No	☐ Not Sure
Varicella (or history of chickenpox)	☐ Yes	When	☐ No	☐ Not Sure
Yellow Fever	☐ Yes	When	☐ No	☐ Not Sure
Zoster (Shingles)	☐ Yes	When	☐ No	☐ 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.

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