



# PATIENT REGISTRATION FORM (Side 1 of 2)

5601 Norris Canyon Road, Suite 220 • San Ramon, CA 94583  
Phone: (925) 277-2050 • Fax: (925) 275-1018 • [www.travelvax.com](http://www.travelvax.com)

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Street

City State Zip

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Male  Female

Hm Phone: ( ) - Wk Phone: ( ) -

How did you hear about our services?  Family/Friend \_\_\_\_\_  Internet

Dr. Referral \_\_\_\_\_  Other \_\_\_\_\_  
Name and Address of Referring Doctor

## PHYSICIAN INFORMATION

Name: \_\_\_\_\_ Phone: ( ) -

Address: \_\_\_\_\_  
Street

City State Zip

## PLANNED TRAVEL ITINERARY

Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_

Please list the Cities/Countries you will travel to (in order):

Approximate length of stay in each country:

1.	City	Country	Length of Stay
2.	City	Country	Length of Stay
3.	City	Country	Length of Stay
4.	City	Country	Length of Stay
5.	City	Country	Length of Stay

Reason for trip:  Pleasure  Business  Student  Humanitarian Aid  Other: \_\_\_\_\_

Which best describes your lodging accommodations while traveling (please check all that apply):

- Major Resort Hotels
- Camping
- Safari
- Rented Foreign Home
- Small Hotels
- Cruise Ships
- Staying with Family
- Youth Hostel
- Other: \_\_\_\_\_

Are you planning to travel outside urban areas?  Yes  No Are you planning to go hiking or backpacking?  Yes  No

Will you visit rural areas in the evening hours?  Yes  No Are you planning to do any cycling?  Yes  No

Do you plan to travel or climb to high altitudes?  Yes  No Do you plan to scuba dive?  Yes  No



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**PERSONAL MEDICAL INFORMATION**

Please answer the following questions to the best of your knowledge.

List any medical conditions or disorders (including heart and lung disease, diabetes or other acute or chronic problems):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications you are taking on a regular basis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic (or hypersensitive) to any medications, foods or bites/stings?  Yes  No If Yes, please list on the line below:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever fainted after an injection or blood draw?  Yes  No

FEMALES ONLY: Are you pregnant?  Yes  No Trying to get pregnant?  Yes  No Are you nursing?  Yes  No

**IMMUNIZATION HISTORY**

Please check the box to the left of any immunization shots you have received along with the date (if known). Check the box to the right if you have had any of the below diseases.

Immunization	Date	Had Disease	Immunization	Date	Had Disease	Immunization	Date	Had Disease
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/>	<input type="checkbox"/> Measles	_____	<input type="checkbox"/>	<input type="checkbox"/> Rabies	_____	<input type="checkbox"/>
<input type="checkbox"/> Cholera	_____	<input type="checkbox"/>	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/>	<input type="checkbox"/> TB Test (PPD)	_____	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/>	<input type="checkbox"/> Rubella	_____	<input type="checkbox"/>	<input type="checkbox"/> Tetanus/Diphth	_____	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/>	<input type="checkbox"/> MMR	_____	<input type="checkbox"/>	<input type="checkbox"/> Typhoid Fever	_____	<input type="checkbox"/>
<input type="checkbox"/> Influenza	_____	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/>	<input type="checkbox"/> Yellow Fever	_____	<input type="checkbox"/>
<input type="checkbox"/> Meningococcal	_____	<input type="checkbox"/>	<input type="checkbox"/> Polio	_____	<input type="checkbox"/>	<input type="checkbox"/> HPV	_____	<input type="checkbox"/>
<input type="checkbox"/> Other:	_____							

**NOTE:** Payment is due on receipt of services. Cash, Check, or Visa/MC/ are accepted. We regret that we are unable to bill your insurance company for you, but we will provide a complete and itemized statement, which you may use for requesting reimbursement.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_