Paitient Information Form
Print, fill out and bring to your appointment

BarnesCare Travelers' Health Service -- 314.331.3050

Patient
last name ______________________ middle initial _____
first name ______________________
address _______________________
(address line #2) ___________________
city _____________ state_______ ZIP _______
home phone (____) ____ - _______
social security number ____ - ___ - _____
age _____
date of birth (month-day-year) ____ / ____ / ____

- ☐ single
- ☐ married
- ☐ widowed
- ☐ divorced

- ☐ male
- ☐ female

Employer
Employer ___________________
work address __________________
(work address line #2) ___________________
city ____________ state ________ ZIP ________
work phone (____) ____ - _____
occupation ______________________

How did you hear about us?
- ☐ employer
- ☐ physician
- ☐ friend
- ☐ web site
- ☐ other________________

Would you like your vaccine information forwarded to your physician?
- ☐ yes
- ☐ no

physician's name ________________
physicians phone number (____) ____ - _____

Would you like to receive email reminders for vaccine follow-ups?
☐ yes
☐ no

Would you like to receive periodic travel health information by e-mail?
☐ yes
☐ no
e-mail address ___________________

Itinerary
In order, list the countries you will be traveling to.
country __________________
city __________________
from (month-day-year) ___/___/_____ to (month-day-year) ___/___/_____
number of days _______
Is this a rural area?
☐ yes
☐ no

country __________________
city __________________
from (month-day-year) ___/___/_____ to (month-day-year) ___/___/_____
number of days _______
Is this a rural area?
☐ yes
☐ no

country __________________
city __________________
from (month-day-year) ___/___/_____ to (month-day-year) ___/___/_____
number of days _______
Is this a rural area?
☐ yes
☐ no

Accomodations
☐ college dormitory
☐ compound
☐ cruise ship
☐ foreign home
☐ hostel
☐ major hotel
☐ resort
☐ safari
☐ small hotel
☐ staying with family
☐ tented camp

☐ other ______________________

Purpose of Travel

☐ adoption
☐ business
☐ field work
☐ foreign study
☐ medical related
☐ mission
☐ research
☐ semester at sea
☐ teaching
☐ trek
☐ vacation
☐ volunteer agency
☐ other__________________________

Previous Vaccines and Diseases

☐ BBG vaccine -- date (month-year) ___/_____
☐ cholera vaccine -- date (month-year) ___/_____
☐ chicken pox -- date (month-year) ___/_____
☐ flu vaccine -- date (month-year) ___/_____
☐ hepatitis A x2 -- date (month-year) ___/_____
☐ hepatitis B x3 -- date (month-year) ___/_____
☐ immune globulin -- date (month-year) ___/_____
☐ Japanese encephalitis -- date (month-year) ___/_____
☐ malaria medication -- date (month-year) ___/_____
☐ meningococcal -- date (month-year) ___/_____
☐ MMR vaccine -- date (month-year) ___/_____
☐ measles/mumps/rubella -- date (month-yea ___/_____
☐ pneumonia vaccine -- date (month-year) ___/_____
☐ polio vaccine -- date (month-year) ___/_____
☐ rabies vaccine -- date (month-year) ___/_____
☐ smallpox vaccine -- date (month-year) ___/_____
☐ TB skin test -- date (month-year) ___/_____
☐ tetanus/diphtheria -- date (month-year) ___/_____
☐ twinrix vaccine -- date (month-year) ___/_____
☐ typhoid vaccine -- date (month-year) ___/_____
☐ varicella vaccine -- date (month-year) ___/_____
☐ yellow fever -- date (month-year) ___/_____
☐ other *(line)* -- date (month-year) ___/_____
☐ military service dates from date (month-year) ___/_____ to date (month-year) ___/_____

General Medical

Do you have a medical condition that warrants medication or physician follow-up?
- [ ] yes
- [ ] no

Are you pregnant or might you become pregnant on this trip?
- [ ] yes
- [ ] no

Have you ever fainted from having your blood drawn or from an injection?
- [ ] yes
- [ ] no

Have you ever had any bad reaction or side effect from any vaccination?
- [ ] yes
- [ ] no

Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia or cancer?
- [ ] yes
- [ ] no

Do you have severe renal impairment?
- [ ] yes
- [ ] no

Do you have a history of problems with your thymus, such as myasthenia gravis?
- [ ] yes
- [ ] no

Do you have any stomach conditions?
- [ ] yes
- [ ] no

Are you currently taking an antibiotic?
- [ ] yes
- [ ] no

Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?
- [ ] yes
- [ ] no

Have you had a fever in the past 48 hours?
- [ ] yes
- [ ] no

Do you have psoriasis?
☐ yes
☐ no

Allergies
Have you ever had a life-threatening allergic reaction to any of these:
eggs
☐ yes
☐ no

yeast
☐ yes
☐ no

gelatin
☐ yes
☐ no

neomycin
☐ yes
☐ no

streptomycin
☐ yes
☐ no

polymyxin B
☐ yes
☐ no

thimerosal
☐ yes
☐ no

Medications
List all medications you are currently taking -- include occasional use and over-the-counter drugs.

drug ___________________
reason for use ___________________

drug ___________________
reason for use ___________________

drug ___________________
reason for use ___________________

drug ____________________
reason for use ____________________

drug ____________________
reason for use ____________________

drug ____________________
reason for use ____________________

I hereby grant permission to BarnesCare, its physicians, nursing staff and other allied health care professionals to provide medical care. I acknowledge that I am financially responsible for services provided to me during each visit. I understand that all oral medication and vaccine provided to me are not returnable or refundable.

For Patients Younger Than 18, Parent-Guardian Authorization Is Required
☐ I release the medical information for my child ____________________ to BarnesCare Travelers' Health Service.
☐ I have read and understand these conditions, and, by submitting this form, consent to these statements.

Signature ____________________________

Date ___/___/_____