3800 N Fairfax Dr., Suite#2
Arlington, VA 22203
703.351.5100

Patient Information Form

Last Name: ______________________ First Name: ____________________ DOB: __________

Age: _____ Sex: _____ Address: ____________________ City/State: __________________ Zip: __________

Telephone: ______________________ Email (for vaccine reminders): ______________________________

Occupation: ______________________ Employer: ______________________________________

How did you hear about us? ____

Name of MD/NP/PA: ______________________________________ City: ________________________

Pharmacy Name/Number/Location: ____

Would you like us to notify your primary care provider about the vaccines you received? ❑ Yes ❑ No

Travel Departure Date: ______________________ Return Date: ______________________________

Countries to be visited (in order, including flight connections)	Length of Stay

Reason for trip: ❑ Business ❑ Tourist ❑ Student ❑ Mission ❑ Other: ____________________

Are you planning to travel outside of urban areas? . . . . ❑ Yes ❑ No

Are you planning to go hiking, camping or backpacking? . . . . ❑ Yes ❑ No

Accomodations: ❑ Hotel ❑ Private home ❑ Hostel ❑ Dorm/barracks ❑ Cruise ❑ Other: ____________

Do You have specific concerns about this trip?

____

____

Have you been ill with a fever in the last 48 hours? . . . . ❑ Yes ❑ No

Have you EVER had any bad reaction from any vaccine (including fainting) . . . . . . ❑ Yes ❑ No

If so, please specify ____

Have you received any of these LIVE vaccines in the last 30 days? (check all that apply)

MMR	❑	Varicella (chicken pox)	❑
Yellow fever	❑	Zostovax (shingles)	❑

Are you allergic to: **(check all that apply)**

Eggs	❑	Any foods ______________________
Latex	❑	Any medications ______________________
Yeast	❑	______________________
Thimerosal	❑	Environmental allergens (pets/dust)
Gelatin	❑	______________________
Bee Stings	❑	Other ______________________

Have you traveled to Africa/South America in the last 30 days? . . . . ❑ Yes ❑ No

If so, where? ______________________

Do you PLAN to have medical or dental procedures on this trip? . . . . ❑ Yes ❑ No

Females only:

Last menstrual period: ______________

Are you currently preventing pregnancy? ❑ Yes (How? ______________) ❑ No

Are you pregnant/trying to get pregnant? ❑ Yes ❑ No

Are you breastfeeding? ❑ Yes ❑ No

If breastfeeding, is child under 9 months of age? ❑ Yes ❑ No

MEDICAL HISTORY

Have you EVER had: **(check all that apply)**

Heart disease/arrhythmia (with or without symptoms)	❑	Thymus condition/myasthenia gravis/DiGeorge Syndrome/thymoma	❑
Lung disease/asthma/wheezing/COPD	❑	Bleeding disorder	❑
Diabetes	❑	Cancer/Leukemia/Lymphoma If so please specify ______________	❑
Liver disease/hepatitis/jaundice	❑		
Kidney disease	❑	Immune deficiency/disorder	❑
Stomach condition/gastritis/reflux/IBS	❑	HIV/AIDS	❑
Depression/anxiety/psychiatric disorder	❑	A transplant If so, please specify ______________	❑
Seizure/epilepsy/neurologic disease	❑		
G6PD deficiency	❑		

Do you live/work closely with someone who has cancer/HIV/AIDS or immune deficiency? . . . . . ❑ Yes ❑ No

Do you live/work closely with someone who is taking steroids/Prednisone/chemotherapy/immune modifying drugs? . . . . ❑ Yes ❑ No

Do YOU take immune modifying drugs? . . . . ❑ Yes ❑ No

If so, please specify______________________

Please list current prescription and over the counter medications you are taking:

____

____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

SIGNATURE ______________________ **DATE** ______________

IF PARENT/GUARDIAN IS SIGNING FOR A MINOR, ALSO PRINT YOUR NAME CLEARLY:

____

Prescription Refill Policy

CTM will fill telephone requests for prescription refills ONLY IF the patient has been seen in our office and has updated their patient information form within the past 12 months.

I understand and agree to CTM's prescription refill policy:

____

Full Name of Patient (please print clearly)

____

Signature

____

Date