Tower Villas Condominium Complex
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): ______________________________

Permission for text appointment reminders: . . . . ❑ Yes ❑ No

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: ____________

Any 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:

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I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

SIGNATURE ____ **DATE** ___________________________

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

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