

Nashville Travel Medical Services

Travel Medicine Questionnaire

Name _____ Home Phone # _____ Work Phone # _____
Address _____ City _____ State _____ Zip _____
SS# _____ Birthdate _____ Age _____ Sex Male Female

Please complete the following information as best you can. It will help us determine what kind of disease protection and advice you will need.

Your Travel Plans

Departure Date _____ Return Date _____

Please list the countries you will visit in sequence if possible: _____

Please check any of the following which may apply to your travel:

- scuba diving camping overnight stay in rural areas household or sexual contact with locals
 if your travel will involve other than routine business or vacation activities, please inform us of the details during your visit.

Medical History

Drug Allergies _____ Are you pregnant? Yes No

Current Medications: _____

Check all that apply:

- heart disease lung, liver or kidney disease hypertension ulcer disease egg allergy
 immunosuppression (chemotherapy, steroids, prednisone, radiation therapy, HIV infection)
 thimersol (a mercury derivative) allergy fainting after injections allergy to any vaccine
 measles history hepatitis history diabetes history of seizures

Check all of the immunizations you have ever had and indicate approximate date of last dose if known:

- tetanus _____ diphtheria _____ oral polio _____
 injections for polio _____ hepatitis A _____ hepatitis B _____
 typhoid oral _____ typhoid injections _____ yellow fever _____
 pneumonia _____ influenza _____ measles or MMR _____
 meningococcal vaccine _____ Japanese encephalitis vaccine _____

CONSENT FOR SERVICES: I understand that, while remarkably safe, vaccines can, in rare instances, cause complications including death. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease.

I also understand that NTMS does not file claims for nor accept any form of insurance payment and does not have any contract with any insurance plan. **(You will be provided with a record of our services and your payments which you may file to claim any reimbursement provided by your insurance plan.)** I understand that my health insurance is a contract between me and my insurance company and does not involve NTMS. I understand that NTMS will not refund any difference between my insurance reimbursement and NTMS charges.

Print Name

Signature

Date



Optional

Consent for NTMS to send a copy of my visit record to my personal physician, whose name and address appear below:
