



PATIENT QUESTIONNAIRE

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU TO YOUR TRAVEL CLINIC APPOINTMENT

****Bring With You Any Immunization Records You May Have****
(You may have to check with previous health care providers to get all this information)

Please Print

Name:	Date of Birth:	Sex: M/F
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Address and Day Time/Evening Phone Numbers:

Name/Address/Phone Number of your Primary Care Physician. **Can we inform your PCP of the immunizations you receive at our clinic? Yes/No (please circle one)**

Please note below any diseases you have had, with dates if possible, and list the vaccinations you have had and the dates on which you had them		
Disease Name	Had Disease (List Date if Possible)	Had Vaccines-List Dates
Measles (rubeola)		
Mumps		
Rubella (German Measles)		
Chicken Pox (varicella)		

Have you received at least 3 doses of tetanus/diphtheria (Td) vaccine in the past (this includes DPT doses as a child)?	Yes	No
When was your last tetanus/diphtheria shot given?		
Have you received at least 3 doses of polio vaccine (this includes childhood doses)?	Yes	No
When was your last dose of polio vaccine given?		

Circle any of the following you are allergic to:
 Eggs Thimerosal Sulfa Neomycin Streptomycin Bee/Wasp Stings

Other Allergies:

Are you currently being treated for cancer? Yes/No

Do you have a deficiency of the immune system? Yes/No

Do you have any **existing medical conditions**, such as diabetes, heart disease, or lung disease?
Please explain:

List all medications you are currently taking, either prescription or over-the-counter:

INFORMATION ABOUT YOUR TRAVEL PLANS:

Date of Departure:

Length of Trip:

Please indicate, in the order in which you will visit them, the countries to which you will be traveling.
Also indicate length of stay in each country (bring complete details of itinerary to your appointment).

Is your travel to: urbanized areas /rural areas /urban and rural areas (please circle one)

What is your reason for travel (pleasure, business, medical work, etc)?

Business Name and Address:

How did you hear about our services?

QUESTIONS FOR WOMEN

Are pregnant, suspect you may be pregnant, or trying to become pregnant? Yes / No

Are you breastfeeding? Yes / No

If pregnant, how many weeks?

Do you have any special concerns or questions to be answered at your appointment?



*In order to help us serve the public better, please tell us how you heard about RVNA's
Travel Clinic*

Please check all that apply:

- News Times On Line _____
- News Times flyer Insert _____
- News Times advertisement weekly paper _____
- News Times Bridal Supplement _____
- Health & Fitness newspaper supplement _____
- Newtown Guide _____
- NFCAR realtor magazine _____
- Wilton Magazine _____
- Surroundings Magazine _____
- Ridgefield Magazine _____
- RVNA Today Column in Ridgefield Press _____
- 4 Seasons Plasma Screen _____
- Phone Book: where? _____
- Online
 - CDC website _____
 - International Society of Travel Medicine (ISTM) website _____
 - Other travel vaccine website _____
 - Other website (please name) _____
- Physician Referral: who? _____
- Friend _____
- Other: please list _____



Travel Clinic Price List
(price is per dose)

Travel Clinic Consultation	\$50 (one time fee)
Tetanus-Diphtheria (TD)	\$30
Hepatitis A	\$130
Hepatitis B	\$95
Twinrix	\$195
Japanese Encephalitis*	\$185
MMR	\$75
Polio	\$55
Rabies*	\$225
Typhoid (oral OR injectable)*	\$100
Varicella	\$150
Yellow Fever*	\$125
Menomune*	\$125
Menactra*	\$125
Tetanus-Diphtheria-Pertussis (Tdap)	\$60
Pneumococcal	\$52
HPV	\$180
Shingles	\$200
Mantoux Testing	\$25

We will furnish you with a receipt that is suitable to submit to your insurance company for reimbursement. Typically, insurance companies will only reimburse for routine immunizations, not immunizations needed for travel.

*These vaccines are usually considered “travel vaccines” by insurance companies. For further information, you can speak to the nurse at your consultation or contact your insurance company directly.