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The Traveler's Medical Clinic

PATRICIA RUGGERI-WEIGEL, M.D., F.A.C.P.
INFECTIOUS DISEASES
TRAVEL MEDICINE

We thank you for scheduling an appointment with Dr. Patricia Ruggeri-Weigel for a travel consultation. Enclosed you will find history forms and a HIPAA consent form. Please fill them out and bring them with you to your appointment. Please arrive approximately 15 minutes prior to your scheduled time to allow time to register.

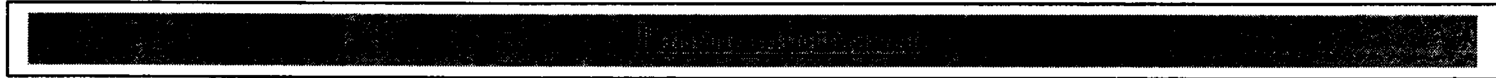
Please make sure that you have a list of any vaccines you may have previously received along with the dates of vaccination. If you are bringing a child please bring their vaccination records from their pediatrician. If we do not have your records it may require an additional follow up visit.

Please make sure that you bring along a list of your current medications and any medical problems as this will help Dr. Ruggeri-Weigel determine what vaccines you may need.

We want to remind you that most insurance companies do not pay for travel vaccinations and therefore we require payment in full at the time of your visit. We accept cash, check, Visa, Mastercard, and American Express. If you request, we will provide you with documentation that you may submit to your insurance company.

Thank you for your cooperation. We look forward to seeing you and providing you with exceptional care.

Dr. Patricia Ruggeri-Weigel and the staff of Traveler's Medical Clinic.



Patients Name: Last ______________________ First ______________________ M.I. _____

Home Address: ____

City: ________________________________ State: _________ Zip Code: ____________

Home Phone: (_____)____________________ Cell Phone:(_____)________________________

Employer: __________________________________ Work No: (______)____________________

Age: ________ Date Of Birth: _______/______/ _______ SS#: ________________________

Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other ☐

Immunizations:

Please check Yes or No to the following questions:
(These include childhood Vaccines)

Had Rubella (German Measles), received Rubella Vaccine?	**YES** ☐	**NO** ☐
Had Mumps or received Mumps Vaccine?	**YES** ☐	**NO** ☐
Had Measles or received Measles Vaccine?	**YES** ☐	**NO** ☐
Have you received at least 3 doses of Polio Vaccine?	**YES** ☐	**NO** ☐
When did you receive your last polio Vaccination?	______________	
Which Polio Vaccine did you receive?	**Oral** ☐	**Injectable** ☐
Did your last tetanus shot include Diphtheria?	**YES** ☐	**NO** ☐
Have you had Hepatitis B Vaccine?	**YES** ☐	**NO** ☐
When were you last tested for Tuberculosis?	**YES** ☐	**NO** ☐
Have you received the BCG vaccine for Tuberculosis?	**YES** ☐	**NO** ☐
Have you ever had reactions to Immunizations?	**YES** ☐	**NO** ☐

Please Explain: ____

____

Do you have any allergies to the following Items?

Eggs ☐ **Medicine** ☐ **Grasses or Molds** ☐ **Feathers** ☐ **Sunlight** ☐
Mercury (Thinerosal) ☐ **Vaccines** ☐ **Antibiotics** ☐ **Formaldehyde** ☐

Are their any other Drugs to which you have had an allergic reaction? ____________________

Are you being treated for leukemia, lymphoma, cancer, or any other malignant disease?	**YES** ☐	**NO** ☐
Do you have a history of deficiency of the immune system?	**YES** ☐	**NO** ☐
Do you have a history of anemia or any other blood disorder?	**YES** ☐	**NO** ☐

Do you have any existing medical condition such as diabetes, heart disease, or pulmonary disease?
If so Please List: ____

When was your last X-Ray performed: ______________Are you on steroids?
YES ☐ **NO**

WOMEN ONLY

Are you pregnant, suspect you may be pregnant or trying to become pregnant? **YES** ☐ **NO** ☐

Please list all your medications:

____

____

Travel Information

Date of Departure: ________________ Return Date: ____________________

Please indicate, in order which countries you will be traveling to and also the length of your stay:

Destination (City, Country)	**Where you will stay**	**Length of Stay**

Who else are you traveling with: ____________________________________

Will children be traveling with you? **YES** ☐ **NO** ☐

IF yes please list their names and date of birth: ____________________________

____

Please circle all that apply to your travel plans:

Major Resort Hotels	Cruise Ships	Camping	Rural Travel
Staying with a family	Small Hotels	Safari	Outdoor Activities
Rented foreign homes	Youth Hostel	OTHER: __________________	

What is the purpose of your travel, (Please Circle)?

Business	Student	Vacation	Missionary
Teacher	Volunteer agency	Fieldwork	Climbing
Diving	Other: ____________________		

Please check and date all the travel vaccines you have received:

☐ Yellow fever __/__/__	☐ Flu vaccine __/__/__	☐ Plague __/__/__
☐ Hepatitis B __/__/__	☐ Hepatitis A __/__/__	☐ Measles __/__/__
☐ Doxycycline __/__/__	☐ Flu vaccine __/__/__	☐ Mumps __/__/__
☐ Meningococcal __/__/__	☐ Malaria Drug __/__/__	☐ Rabies __/__/__
☐ Immune Globulin __/__/__	☐ Cholera __/__/__	☐ Rubella __/__/__
☐ Polio- Oral or Inject able __/__/__	☐ Japanese Encephalitis __/__/__	
☐ Pneumococcal Vaccine __/__/__	☐Tuberculin test __/__/__	
☐ Tetanus Diphtheria __/__/__	☐ Typhoid – Oral or Injectable	

Goals for your Travel Medicine service visit: ________________________________

____

How did you hear about our services: _____________________________________

Name, address and phone number of Family physician:

____

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The Traveler's Medical Clinic

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the Traveler's Medical Clinic to use and disclose protected Health information (PHI) about me to carry out treatment, payment and healthcare Operation (TPO). (The Traveler's Medical Clinic's Notice of Private Practiced provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Traveler's Medical Clinic reserves the right to revise its Notice of Privacy Practices at anytime.

With this consent, The Traveler's Medical Clinic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, The Traveler's Medical Clinic may mail, email or fax (to a secured fax line) or other alternative location any items that assist the practice in carrying out TPO, such as appointment, reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that The Traveler's Medical Clinic restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to The Traveler's Medical Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, The Traveler's Medical Clinic may decline to provide treatment to me.**

____
Signature of Patient or Legal Guardian

____________________________________ ________________________
Patient's Name Date

____
Print Name of Legal Guardian (if required)