Cooper Pediatrics

TRAVEL MEDICINE QUESTIONNAIRE

Patient Name:
DOB:
Account No:

PLEASE PRINT			
Legal Name of Traveler:			
Gender:	DOB:	Birthplace:	
Home Address:			
City:	State:	Zip:	
Home Phone:	Business Phone:		
Primary Care Physician:	Phone:		
Emergency Notification:	Phone:		
Relationship:			

ITINERARY

Departure Date:	Return Date:	Length of Trip:

PURPOSE OF TRAVEL

☐ Business	☐ Field Worked	☐ Relocation	☐ Teaching/Study	☐ Missionary Work
☐ Vacation	☐ Diving	☐ Safari	☐ Climbing	☐ Other

TYPE OF TRAVEL

☐ Group/Tour	☐ Independent	☐ Fixed Itinerary
☐ Flexible Itinerary	☐ Cruise	☐ Other:

ACCOMMODATIONS

☐ Compound	☐ Hotel/Resort	☐ Private Home	☐ Cruise ship	☐ Offshore Rig

DESTINATION, INCLUDING AIRPORT STOPOVERS. LIST IN ORDER OF TRAVEL:

Country	City	Duration	Urban (X)	Rural (X)

NOTICE OF ADVANCE PAYMENT REQUIRED

THIS IS NOTICE TO INFORM YOU THAT MOST HEALTH PLANS DO NOT OFFER COVERAGE FOR IMMUNIZATIONS FOR THE PURPOSE OF TRAVEL. THEREFORE, COOPER PEDIATRICS WILL NOT FILE A CLAIM FOR THIS VISIT WITH YOUR HEALTH PLAN. PAYMENT, IN FULL, IS EXPECTED AT THE TIME OF YOUR VISIT. FURTHER, THESE SERVICES ARE NOT SUBJECT TO ANY EXISTING DISCOUNT POLICIES.

YOU MAY CHOOSE TO FILE A CLAIM DIRECTLY WITH YOUR HEALTH PLAN. YOU MAY ALSO CHOOSE TO CONTACT YOUR HEALTH PLAN PRIOR TO THE VISIT TO REQUEST A BENEFITS REVIEW FOR "TRAVEL MEDICINE SERVICES." IF YOU ARE ABLE TO BRING WRITTEN PROOF FROM YOUR HEALTH PLAN SHOWING EVIDENCE OF COVERAGE FOR "TRAVEL MEDICINE" SERVICE, COOPER PEDIATRICS MAY BE ABLE TO FILE THE CLAIM ON YOUR BEHALF.

REVIEWED AND ACCEPTED: _____ Date: _____

Immunization History (check "Had Disease" if applicable or list date of appropriate vaccination):					
	Had Disease	**Vaccine # 1 date**	**Vaccine # 2 date**	**Vaccine #3 date**	**Not Known**
Chickenpox					
Hepatitis A					
Hepatitis B					
Rabies					
Japanese Encephalitis					
Measles					
Mumps					
Rubella					
Meningitis					
Polio					
Pneumococcal					
Influenza					
Tetanus/Diphtheria					
Typhoid Injection					
Typhoid Oral					
Yellow Fever					

Do you have an "International Certificate of Vaccination"?	☐ Yes	☐ No

Have you ever fainted or had an adverse reaction to any of the following:

Vaccines:	☐ Yes ☐ No	Bee Stings:	☐ Yes ☐ No

Do you have cancer, leukemia, AIDS or other immune system problems? ☐ Yes ☐ No

Do you take Cortisone, prednisone, other steroids, anti-cancer drugs or have/had radiation therapy? ☐ Yes ☐No

Have you received a blood transfusion, blood products or immune globin in the past year? ☐ Yes ☐ No

Have you had any immunizations in the past 4 weeks? ☐ Yes ☐ No

If yes, please explain:

HEALTH HISTORY

Weight:	Height:	Allergies:

MEDICATIONS (LIST ALL MEDICATIONS, INCLUDING DOSAGES)

Prescription	**Non-Prescription**

Medical Conditions:

Previous Surgery:

Do you have a history of the following:

Nightmares: ☐ Yes ☐ No	Psoriasis: ☐ Yes ☐ No	Seizure/Epilepsy: ☐ Yes ☐ No
Psychiatric Disorders/Depression: ☐ Yes ☐ No	Stomach/Colon Problems: ☐ Yes ☐ No	

Women: Type of contraception, if applicable:

Pregnant: ☐ Yes ☐ No	Planning pregnancy within 3 months: ☐ Yes ☐ No	Nursing: ☐ Yes ☐ No

I verify that the above information is complete and correct to the best of my knowledge.

_____ _____

Signature Date

***PLEASE BRING YOUR YELLOW TRAVEL CARD OR IMMUNIZATION RECORD TO YOUR VISIT.