Adventure Doc clinic™
keeping you healthy for life's adventures

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____
First Middle Last

Address: _____
Street

_____
City State Zip

E-mail: _____ Date Registered: _____

Date of Birth: _____ Age: _____ Weight: _____ Sex: ☐ Male ☐ Female

Hm Ph: _____ Cell Ph: _____

Work Ph: _____ Emrg Ph: _____

How should we contact you? ☐ Phone ☐ Mail ☐ Email

How did you hear about our services? ☐ Internet ☐ Friend/Family: _____
☐ Company: _____ ☐ Other: _____

☐ Dr. Referral: _____
Name/Address of referring doctor

Have you ever fainted after an injection or blood draw? ☐ Yes ☐ No

IMMUNIZATION HISTORY

Please check the box to the left of any immunization shots you have received along with the date (if known).
Check the box to the right if you have had any of the below diseases.

Immunization		Date	Had Disease	Immunization		Date	Had Disease
Chicken Pox	☐		☐	Mumps	☐		☐
Cholera	☐		☐	Rubella	☐		☐
Hep A 1 & 2	☐		☐	MMR	☐		☐
Hep B 1, 2, 3	☐		☐	Pneumonia	☐		☐
Hep A/B 1,2,3	☐		☐	Polio	☐		☐
HIB	☐		☐	Rabies	☐		☐
HPV	☐		☐	Shingles	☐		☐
H1N1	☐		☐	TB Test (PPD)	☐		☐
Influenza	☐		☐	Tetanus/Dipth	☐		☐
Jap. Encephalitis	☐		☐	Tdap(whoop cough)	☐		☐
Meningitis	☐		☐	Typhoid	☐		☐
Measles	☐		☐	Yellow Fever	☐		☐

Other: _____

PERSONAL MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge.

List any medical conditions or disorders (including heart & lung disease, diabetes or other acute or chronic problems):

_____

_____

Do you have any problems with your immune system (e.g., HIV, spleen removal, lymphoma, leukemia, receiving chemotherapy or radiation therapy, taking prednisone/steroids)?

_____

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Do you have a history of seizures? ☐ Yes ☐ No

Do you have a history of thymus (not thyroid) problems? ☐ Yes ☐ No

List all medications you are taking on a regular basis:

_____

_____

Check if you have an allergy to any of the following: ☐ Eggs ☐ Thimerosal ☐ Sulfa ☐ Neomycin ☐ Streptomycin ☐ Bee Stings

Are you allergic (or hypersensitive) to any other medications or foods? ☐ Yes ☐ No
Please list: _____

PRIMARY PHYSICIAN INFORMATION:

Name: _____ Phone: _____

Address: _____

_____

Females Only: Are you pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Last menstrual period: _____

PLANNED TRAVEL ITINERARY Departure date: _____ Return date: _____

Please list the cities/countries you will travel to (in order): Approx. length of stay in each country

City/Destination	Country	Length of stay

Reason for trip: Pleasure Business Student Volunteer Work Visiting Friends/Relatives
Please circle all that apply

Accommodations: Camping Cruise Ship Family Hotels Rent Home Safari Youth Hostel
Please circle all that apply

	Yes	No		Yes	No
Are you planning to travel outside urban areas?	☐	☐	Humanitarian aid?	☐	☐
Will you visit rural areas in the evening hours?	☐	☐	Research/Field Work?	☐	☐
Do you plan to travel or climb to high altitudes?	☐	☐	Tour group?	☐	☐
Are you planning to go hiking or trekking?	☐	☐	Rural travel?	☐	☐
Are you planning to do any cycling?	☐	☐	Major Resort Hotels?	☐	☐
Do you plan to scuba dive?	☐	☐	Private Home?	☐	☐

Note: Payment is due on receipt of services. Cash, Check or Credit Cards are accepted. We regret that we are unable to bill your insurance company for you, but we will provide a complete and itemized statement, which you may use for requesting possible reimbursement.

Signature: _____ Date: _____