



## LCN Services LLC Travel Vaccines Questionnaire

Date: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Birth Sex: Male \_\_\_ or Female \_\_\_

Date of Birth \_\_/\_\_/\_\_\_\_\_

Age \_\_\_\_\_

E-Mail \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cellphone \_\_\_\_\_

Please place one check on the question: Referred by: Doctor \_\_\_\_\_ CDC Website \_\_\_\_\_

Search Engine \_\_\_\_\_ Friend/ Relative/ Coworker \_\_\_\_\_ Your Website \_\_\_\_\_ Another

Website \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

### Type of Service(s) Requested

#### Medical History Required for all services

**OFFICE SERVICES - Payment is expected at time of office visit. Please put an X or check mark next to services needed.**

\_\_\_ Office Consultation \$75. Appointment must be made.

\_\_\_ Second person Consultation \$45

\_\_\_ Vaccines for Travel. Administration fees plus cost of vaccines. Client knows which vaccines he wants

\_\_\_ Vaccines for Non-Travel Only- Administration fees plus cost of vaccines. May Skip the Travel

Section of the Questionnaire



\_\_\_ Prescriptions for Travel \$25. Such as malaria, attitude sickness, traveler's diarrhea. Please list in "Vaccines and Prescriptions" section below

\_\_\_ PPD (Tuberculosis Screening) \$25

**Travel Information -Please skip if not Traveling**

Medical History is also Required for all travelers.

Please list the countries you are traveling to and the length of stay in each country below:

\_\_\_\_\_

Departure Date \_\_/\_\_/\_\_\_\_ Return Date \_\_/\_\_/\_\_\_\_

Please indicate the reason for travel: Tourist \_\_\_ Business \_\_\_ Mission \_\_\_

Visiting Friends/ Relatives \_\_\_ Other \_\_\_\_\_

Accommodations: Check all that apply

Hotel \_\_\_ Youth Hostel \_\_\_ Family/Home \_\_\_ Cruise \_\_\_ Camping \_\_\_

Check all that apply. I plan to:

Visit Rural Areas \_\_\_ Visit only tourist areas \_\_\_ Scuba dive \_\_\_ Go bicycling \_\_\_

Swim in Ocean \_\_\_ Travel to or climb to high altitudes \_\_\_ Swim in freshwater lake or stream \_\_\_

Go hiking or backpacking \_\_\_ Drive car or motor scooter \_\_\_

**Vaccines and Prescriptions**

Medical History Required for these services

Are you requesting prescription for Malaria: YES \_\_\_ or No \_\_\_

Prescriptions for Malaria and other Medications: If you already know what you want, please list here:

\_\_\_\_\_

\_\_\_\_\_



Vaccines- If you already know what you want, please list here:

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### Medical History

Medical History Required for all services

Current Medications: None \_\_\_\_\_

List Medications here:

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Current or Previous Medical Conditions: None \_\_\_\_\_

List Conditions here:

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Please Check Yes or No. Use the additional comments area to provide additional information



	Yes	No
Any adverse reactions to a previous immunization?		
Are you pregnant or suspect that you might be pregnant?		
Any known allergies to medications, etc?		
Do you have a cold, fever, wheezing, or any other acute illness?		
Any sensitivity/allergy to latex, eggs, insect/bee stings, quinine, or thimersal (cleaning products or contact lens solution)?		
Do you have a chronic mental or physical condition?		
Do you have a history of Gillian-barre Syndrome, seizures, high blood pressure, eczema, motion sickness, or active neurological disorder?		
Do you, or any person you are in close contact with, have immune system problems including HIV/Aids, cancer, or leukemia?		
Do you have a history of depression or anxiety?		

Additional Comments:

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### **PAYMENT for OFFICE SERVICES**

\_\_\_ I understand that for office services payment is expected at time of service, in the office, with cash, debit, or credit card.

### **CONFIRMATION**

\_\_\_ The above information is true and accurate to the best of my knowledge.

What is your relationship to patient? Please place check below:

self \_\_\_                      parent \_\_\_                      guardian \_\_\_                      spouse \_\_\_

Print Full Legal Name: \_\_\_\_\_

Signature: \_\_\_\_\_