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PATIENT'S NAME (LAST, FIRST MIDDLE)					HOME PHONE
PATIENT'S HOME ADDRESS		APT NO.	CITY	STATE	ZIP
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)					BUSINESS PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH MM/DD/YY	AGE	SEX	SPOUSE'S NAME	
PATIENT'S OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS		
EMAIL ADDRESS			DO YOU WISH TO RECEIVE THE FOXHALL INTERNISTS EMAIL NEWSLETTER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
EMERGENCY CONTACT	ADDRESS		PHONE NUMBER	RELATIONSHIP	
PERSONAL PHYSICIAN:			REFERRED BY:		
<p>INSURANCE: Most insurance plans do not cover travel immunizations; therefore, we are an out-of-network provider. We will submit one courtesy claim for those patients covered by Blue Cross/Blue Shield or Medicare.</p> <p>Primary Insurance: _____ ID# _____ Group # _____ Subscriber's Name: _____ Relationship: _____</p>					

MEDICAL HISTORY

ALLERGIES (FOOD, DRUGS, ENVIRONMENTAL FACTORS):

1. _____ 2. _____
3. _____ 4. _____

Do you have any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure disorder/epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart rhythm problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychiatric disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Thymus Disease |

Are you at risk for Immune Deficiency? Yes No

Are you currently taking any medications (including over-the counter drugs)? Yes No

If yes, please list:

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Have there been any changes in the medications since your last appointment? Yes No Not Applicable

Have there been any changes in your health since you were last here? Yes No Not Applicable

TRAVEL RELATED APPOINTMENTS: Is your travel for: Business Pleasure

Destinations: Country(s): _____

Length of Travel: _____ **Date of Departure:** _____ **Will you be in Rural Areas?** Yes No

Today's Date: ____/____/____

MEDICAL HISTORY CONTINUED

Name: _____ Date of Birth _____

Are you, or the person getting the vaccine:

YES NO

Sick with fever?		
Sick with vomiting?		
Sick with diarrhea?		
Allergic to eggs?		
Allergic to neomycin or streptomycin (antibiotics)?		
Had immune serum globulin within the last 3 months?		
Had an allergic reaction or illness of the brain that required medical attention or a hospital stay after receiving any vaccines?		
Ever had a reaction to vaccines in the past, i.e. allergic reaction, high fever ($\geq 105^{\circ}\text{F}$)		
Had any vaccines within the last month? If so, what? _____		

Have you or anyone in the household had any of the following conditions which would make you less able to fight infections?

<input type="checkbox"/> Yes <input type="checkbox"/> No cancer or leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No special cancer treatment such as x-rays or drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No drugs such as prednisone or other steroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No an inborn or inherited disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No other? _____	

Comments: _____

FOR WOMEN ONLY:

YES NO

1. Are you pregnant?		
2. Are you breastfeeding?		
3. Might you possibly be pregnant?		
4. Have you missed a menstrual period?		
5. Date of last menstrual period: _____		
6. Do you understand that you should not become pregnant within 3 months after receiving this vaccine?		
7. Are you using birth control? If yes, what method? _____		
8. For Travel Appointments: Are you considering trying to become pregnant during your stay abroad?		

ALL PATIENTS: PLEASE READ, INITIAL AND SIGN

I understand that receiving these medications does not preclude the need for complete physical examinations by my doctor or the doctor of the person named above for whom I am authorized to make this request.

Initial _____

I understand that Foxhall Internists, P.C. does not participate with any insurance company. I further acknowledge that I am personally responsible for payment of all charges not paid in full by insurance.

Initial _____

I have read the information on this form, or had the information interpreted to me in my language, and have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Patient or Parent/Guardian Signature: _____ **Date** ____/____/____