FOXHALL
INTERNISTS, PC

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Phone 202.362.4467 ♦ Fax 202.364.6513

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PATIENT'S NAME (LAST, FIRST MIDDLE)					HOME PHONE
PATIENT'S HOME ADDRESS	APT NO.	CITY	STATE	ZIP	MOBILE PHONE
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	APT NO.	CITY	STATE	ZIP	BUSINESS PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH MM/DD/YY	AGE	SEX	SPOUSE'S NAME	SPOUSE'S PHONE

PATIENT'S OCCUPATION	EMPLOYER	EMPLOYER'S ADDRESS

EMAIL ADDRESS	DO YOU WISH TO RECEIVE THE FOXHALL INTERNISTS EMAIL NEWSLETTER? ☐ Yes ☐ No

EMERGENCY CONTACT	ADDRESS	PHONE NUMBER	RELATIONSHIP

PERSONAL PHYSICIAN:	REFERRED BY:

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.

Primary Insurance: _____ ID# _____ Group # _____

Subscriber's Name: _____ Relationship: _____

MEDICAL HISTORY

ALLERGIES (FOOD, DRUGS, ENVIRONMENTAL FACTORS):

1. _____ **2.** _____

3. _____ **4.** _____

Do you have any of the following?

☐ Yes ☐ No **Psoriasis**
☐ Yes ☐ No **Cancer**
☐ Yes ☐ No **High Blood Pressure**
☐ Yes ☐ No **Hepatitis**
☐ Yes ☐ No **Seizure disorder/epilepsy**
☐ Yes ☐ No **Kidney Disease**
☐ Yes ☐ No **Depression**
☐ Yes ☐ No **Heart rhythm problems**
☐ Yes ☐ No **Other psychiatric disorder**
☐ Yes ☐ No **Diabetes**
☐ Yes ☐ No **Asthma**
☐ Yes ☐ 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: ____/____/____

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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 (≥ 105°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?

☐ Yes ☐ No **cancer or leukemia?**
☐ Yes ☐ No **special cancer treatment such as x-rays or drugs?**
☐ Yes ☐ No **drugs such as prednisone or other steroids?**
☐ Yes ☐ No **an inborn or inherited disease?**
☐ Yes ☐ 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** ____/____/____