Travel Medicine Visit Form

Welcome to Silver Sage Center for Family Medicine! We'd like to thank you for choosing us to help keep you healthy during your upcoming trip. We are one of the few offices in Northern Nevada that can provide travelers any vaccination they need to travel the planet. Our goal is to get you what you need so you can avoid developing preventable diseases away from home

Travel medicine, however, isn't just about vaccinations. Our goal is to do an overall overview of your health and understand the risks associated with your particular trip. Understanding all of this will help us partner with you to review the current CDC recommendations and give you the best advice so that you can enjoy your upcoming trip abroad without worry.

To Get Started....

Sooner is generally better than later for travel medicine. Because your body takes some time to make antibodies to vaccines (which is what gives you immunity), we suggest you contact us as soon as you know your travel plans. Also, some vaccines require multiple shots spaced out to get full efficacy.

Try to complete as much of this form as you can. If you don't know all the answers, don't worry and we'll discuss it during your visit.

Please bring all of details of your trip to the appointment. Any and all information will be appreciated. In many countries, the recommendations can vary by area. The more we know about exactly where you are going, the more specific advice we can give you about what you may encounter on your trip.

Bon Voyage, Buon Viaggo, szczęśliwej podróży, ¡buen viaje and have a great trip!

Silver Sage Center for Family Medicine

Silver Sage
CENTER FOR FAMILY MEDICINE

Silver Sage Center for Family Medicine

Andrew Pasternak, M.D. , Teresa Angermann, D.O. , Jason Crawford M.D. , Melanie Perl A.P.R.N

PEDIATRIC PATIENT INFORMATION SHEET

Name ____
Last First MI Date of Birth

Physical Address____
Address City State Zip

Mailing Address____
Address City State Zip

Patient Phone______________________ Cell_________________________ Work ________________________

Parent E-Mail____ Sex: M F

Social Security__________________________ Race____________________ Ethnicity__________________

Parent/guardian Name(s):____

Emergency Contact: ____
Name Phone Relationship

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

<u>Parent Employment Information</u>

Employer: ____

Employer Address: ____

Spouse/Parent: __________________________________ Occupation:_______________________________

Employer: _______________________________________ Work Phone: _____________________________

<u>Insurance Information for Child</u>

Name of Subscriber: _______________________________ Relationship to patient: ___________________

Birth Date of Subscriber: ____________________ Social Security #: _________________________________

Name of Employer: __________________________________ Work Phone: ____________________________

Insurance Co: ____

Policy #: __________________________________ Group #: _______________________________________

Secondary Insurance: ______________________________ Subscriber Name: __________________________

Employer: _______________________________________ Subscriber D.O.B: __________________________

Relationship to patient: ____________________________

I understand that co-payments are due at the time of visit. I authorize payment of medical benefits from my insurance company to Silver Sage Center for Family Medicine. I also authorize the release of any medical information necessary to process any medical claim. **<u>We bill insurance as a courtesy to you</u>. You realize that you are responsible for any balance accrued at the time of visit should your insurance company not cover/pay. You acknowledge receipt of the privacy policies and practices notice (paper copy available by request).**

Signature: ____ Date:______________________

Is there a friend of family member that we may disclose your medical information with? Name and relation: ____

How did you hear about us? ____
We do not discriminate against anyone regardless for color, race, creed or physical ability.

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PATIENT INFORMATION SHEET

Name ____
Last First MI Date of Birth

Physical Address____
Address City State Zip

Mailing Address____
Address City State Zip

Patient Phone_______________________ Cell__________________________ Work ________________________

E-Mail____ Sex: M F Marital Status: S M D W

Social Security ______________________________ Race___________________ Ethnicity__________________

If Minor, Parent Name: ____

Emergency Contact: ____
Name Phone Relationship

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

Employment Information

Employer: ____

Employer Address: ____

Spouse/Parent: ____________________________________ Occupation:_________________________________

Employer: ____ Work Phone: ________________________________

Insurance Information

Name of Subscriber: _________________________________ Relationship to patient: _____________________

Birth Date of Subscriber: _____________________ Social Security #: ___________________________________

Name of Employer: ____________________________________ Work Phone: _____________________________

Insurance Co: ____

Policy #: ____________________________________ Group #: ____

Secondary Insurance: ________________________________ Subscriber Name: ___________________________

Employer: ____ Subscriber D.O.B: ___________________________

Relationship to patient: ______________________________

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____

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Pediatric Health History Form

Child's Name: ____ Date of Birth: _____________ Age: ________
Parents/Guardian: ____
Child's Previous Doctor: _______________________________ Phone: _______________________________
Present Health Concerns: ____
____
Medication/Vitamins: ____
Herbs/Home Remedies: ____
Allergies/Reactions to Medications and Vaccinations: ____
____

Pregnancy & Birth

Where was your child born? ____
Is the child yours by : __ Birth __ Adoption __ Stepchild __ Other: ___________________________
Please indicate any medical problems during pregnancy __ None __ Specify: _____________________
____
Delivery by __ Vaginal __ Caesarean If Caesarean, why? ____
Birth Weight: _________ Birth Length: _________ APGAR score: ___________________________
Please indicate any medical problems during pregnancy. __ None. If premature, how early? _______
____

Nutrition & Feeding

Was your child breastfed? __ No __ Yes If so, how long? __________________________________
Has your child had any unusual feeding problems? __ No __ Yes If yes, specify: _________________
____
Milk intake now: Type __ Cow's Milk(__ 1% __ 2% __ Whole Milk) __ Soy Milk __ Rice Milk
Average ounces per day (Note: 8oz = 1 cup) ____

Sleep

Hours per night _____________ Naps (Number and Length) ___________________________________
Any sleep problems: ____

Development

At what age did your child: Sit alone _____ Walk _____ Say words _____ Toilet train _____
Girls only: Age of first menstrual period: _____________

Immunization/Infectious Disease: Please bring your child's immunization records to your appointment

Has your child had: __ Chickenpox __ Measles __ Rubella __ Meningitis __ Tuberculosis (TB)

Exposures/Habits: any concerns about lead exposure? (old homes/plumbing/peeling paint) __ N __ Y

Do any household members smoke: __ N __ Y
TV Hours per day ______ Computer hours per day ______ Video game hours per day ______

TURN OVER

Past Medical History: Please describe any major medical problems and their dates:

____

____

____

Hospitalizations (with dates): ____

____

Broken bones or severe sprains: ____

____

Social History:

Who lives at home?

Name	Age	Relationship

Are your child's parents __Married __Unmarried __Separated __Divorced If divorced/separated, when?___

Child care situation __ Parents __ Others (specify who and hours per day) _______________________

Concerns about your child: __Alcohol use __Tobacco __Sexual activity __Aggressive behavior __Drug use

Is violence at home a concern? __Yes __No Are there guns in the home? __Yes __No

School History:

Did/does your child attend preschool: __Yes __No

Current grade ________ Name of school ____

Any concerns about school performance? ____

If child is over 4 years old, does child have a best friend? __Yes __No

Sports/Exercise

Type of exercise ____________________________________ How often ___________________

Review of symptoms: Please indicate with an **X** if child has any of the following conditions:

Constitutional
__Fevers/chills
__Unexplained
__weight loss/gain

Cardiovascular
__Tires easily
With exertion
__Shortness of breath
__Fainting

Ears/nose/throat
__Unusually load voice/hard of hearing
__Mouth breathing/snoring

Respiratory
__Cough/wheeze
__Chest pain

Skin
__Rash
__Unusual moles

Allergy
__Hay fever/itchy eyes

Musculoskeletal
__Muscle/joint pain

Gastrointestinal
__Nausea/vomiting
__Diarrhea
__Constipation
__Blood in bowel movements

Blood/lymph
__Unexplained lumps
__easy bruising/bleeding

Eyes
__Squinting/cross-eyes
__Asymmetric gaze

Neurological
__Headaches
__Weakness
__Clumsiness

Psychiatric/Emotional
__Speech problems
__Anxiety/stress
__Problems with sleep/
nightmares

__Frequent runny nose
__Problems with teeth and gums

__Depression
__Bad temper/jealousy

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Adult Health History

Date: ____________
Name: ____ D.O.B. _______________ Gender M F
Occupation: _________________ Highest level of education ___________Birth place _______________________
Marital Status single/married/widowed/divorced/separated
Children (names/ages) ____

__NO KNOWN ALLERGIES

Allergies	Reaction

Medications and dosages:

Medical History

Do you currently have or have had in the past any of the following (check all that apply):

O Allergies (seasonal)	**O** Diabetes	**O** Anemia	**O** Cirrhosis	**O** Depression
O Asthma	**O** GERD (reflux)	**O** Heart attack	**O** Hepatitis	**O** Anxiety
O Benign prostatic hypertrophy	**O** Tension headaches	**O** Obesity	**O** Sexually transmitted disease	**O** Colon Cancer
O Gallstones	**O** Migraine headaches	**O** Osteoarthritis	**O** HIV	**O** Breast cancer
O Congestive heart failure	**O** Hyperlipidemia (high cholesterol)	**O** Osteoporosis	**O** Urinary incontinence	**O** Skin cancer
O COPD (emphysema)	**O** Hypertension (high blood pressures)	**O** Peptic ulcer disease	**O** Chronic sinusitis	**O** Prostate cancer
O Coronary artery disease	**O** Hypothyroidism	**O** Blood clots	**O** Dementia	**O** Lung cancer
O Other _____________				

Surgical History

Have you had any of the following surgeries? If so, what year?

O Appendix___________	**O** Heart____________	**O** Hernia_____________	**O** Stomach___________	**O** Breast augmentation/ reconstruction/biopsy

O Arthroscopy________	O Cataract___________	O Joint replacement___	O Brain_____________	O Thyroid___________
O Biopsy_____________	O Gallbladder________	O Sinus_____________	O Hemorrhoids_______	O Hysterectony_______
O Other_____________				

TURN OVER

Social History

Have you ever smoked? Y N	Do you currently smoke? Y N	Are you interest in quitting? Y N
How much do you smoke? _______pack(s) a day for ______ years	How much alcohol do you drink in a week? ___________________________	Do you use illicit drugs? Y N What kind? _______________________

Do you exercise? Y N If so, how often ___________ What kind of exercise? __________________________

Do you have a living will? Y N Do you have a medical power of attorney? Y N

Do you want information on advanced directives? Y N

Family History

Disease	Father	Mother	Sibling	Grandparents	Children
Diabetes					
Cancer (if so what type)					
Heart disease/attack					
High blood pressure					
Stroke					
Thyroid disease					
Asthma					
Migraine headache					
Obesity					
Anemia					
Bleeding tendency					
Problem with anesthesia					
Depression/anxiety					
Bipolar					
Kidney disease					
Substance abuse					

Immunizations

Last Tetanus _____________	Last Influenza____________	Last Pneumovax__________	Hepatitis B ______________

OB/GYN History

Date of last menstrual period ________	Regular cycles? Y N	Pain/heavy bleeding with periods? Y N
Date of last pap smear _____________	Need for birth control? Y N	Using birth control? Y N
Number of pregnancies ____________	Number of births __________________	Number of abortions ______________
Number of miscarriages ____________	Age of first menstrual period ________	Age of menopause ________________

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Financial Contract/ Agreement

1. I understand that if I do not pay my account with Silver Sage Center for Family Medicine in full, that my account may be assigned to a collection agency for collection.
2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 35% of the amount I owe to Silver Sage Center for Family Medicine. I agree that if my account is assigned to a collection agency, that Silver Sage Center for Family Medicine may add the amount of the collection agency's commission or fee to the amount that I owe Silver Sage Center for Family Medicine, and I agree to pay that additional amount.
3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for (medical/dental) services. I understand, for example, that if the unpaid balance that I owe to Silver Sage Center for Family Medicine is $1000, that Silver Sage Center for Family Medicine may add up to $350 to my account, and I agree to pay the sum of $1350 in such event.
4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

______________________________________ ________________________

Signature of Patient or Guarantor **Date**

Travel Visit Form

(to be completed by traveler)

Name of traveler______________________________

Date you will leave the US:__________ **Date you arrive back in the US:**__________

Total Duration of Travel______________________________________

Destinations:

Country	Region/city	Length of stay

Purpose of trip: ☐ Adventure Trip ☐ Business Trip ☐ Educational Trip ☐ Religious Trip ☐ Pilgrimage ☐ Research ☐Vacation ☐Volunteer ☐ Adoption Trip ☐ Other______________

Any special activities planned: ☐ Biking ☐ Hiking ☐ Mountain Climbing ☐ Scuba Diving ☐ Fresh water activities ☐ Salt water activities ☐ Safari ☐ Camping ☐ Spelunking ☐Other__________

Accommodations (check all that apply) ☐ First Class Hotels ☐ Small Hotels ☐ Cruise Ship ☐ Tour Group ☐ Urban areas ☐ Rural areas ☐ Private homes ☐ Tents/cabins

Are you traveling above 8000 feet(2500m) during your trip _____ Yes _____No
Do you have any history of altitude related illnesses ___Yes ____No
If yes, what happened? ______________________________________

Malaria medicine questionnaire:
Is there any chance you could be pregnant: ____Yes ____No
Previous adverse side effects from malaria medications: ____Yes ____No
Seizures/epilepsy _____Yes ____ No
G6PD Deficiency _____Yes ____ No
Psychiatric disorders _____Yes ____ No
Anemia _____Yes ____No
Tendency to nightmares or anxiety _____Yes ____ No

Sleep disturbance _____Yes ____ No
Sun Sensitivity _____Yes ____ No
Gastrointestinal problems _____Yes ____ No
Thyroid disorder _____Yes ____ No

Flight questionnaire
How long is your longest flight going to be? ______________
How many time zones are you going to change? ____________
History of any blood clots? ____Yes ____No
Family History of blood clots or pulmonary emboli? ____Yes ____No
Severe jet lag or insomnia? ____Yes ____No
Severe flight anxiety? ____Yes ____No
Are you a smoker? ____Yes ____No
Any history of ear issues or sinus issues? ____Yes ____No

Live vaccine questionnaire
Any previous side effects from live vaccines? ____Yes ____No
Any history of immunosuppression (HIV, cancer, chemo or prednisone)? ____Yes ____No
Close to anyone who is pregnant, getting chemotherapy or on prednisose? ____Yes ____No
Any history of seizures? ____Yes ____No
Any history of hepatitis or liver disease? ____Yes ____No
Any history of uncontrolled diabetes? ____Yes ____No
Have you had your spleen removed? ____Yes ____No
Any history of allergies to eggs? ___Yes ____No

Prior immunizations:
Did you grow up in the United States for the first 5 years of your life? ___Yes ____No
Did you have your routine childhood vaccinations ?___Yes ____No
Do you have a record of your immunizations ? ___Yes ____No
Were you in the military? ___Yes ____No

Yearly Influenza___________
Tetanus/diphtheria/pertussis _____________
MMR: #1__________ #2_____________
Last polio ____________ Oral or shot?___________
Did you have chickenpox? ____Yes ____No
If no, have you had chickenpox (varicella) vaccine? ____Yes ____No
Hepatitis A #1__________ #2_____________
Hepatitis B #1__________ #2_____________ #3____________

Meningococcal________________
Shingles______________
Pneumococcal (pneumonia vaccine)______________
Rotavirus_________________
Yellow fever_____________
Rabies vaccine #1___________ #2______________ #3_____________
Japanese Encephalitis #1___________ #2______________

While you are travelling what is the best way to contact you?

Cell phone______________ E-mail_____________________

Emergency Contact_______________ Relationship_______________
Contact phone number______________________________________

For Internal Use Only: MRN______________

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME____
Last *First* *Middle*

PREVIOUS NAME(S)______________________________ **GENDER:** M____ F____

STREET ADDRESS / P.O. BOX______________________________________

CITY__________________________ **STATE**____________ **ZIP CODE**____________

PHONE NUMBER ____________________ **EMAIL**______________________________

DATE OF BIRTH _________(MM)_________(DD)_________(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

____ ______________________
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

______________________________ ____________________ ______________
Name of Authorized Representative (Printed) Relationship Date Time

____
Address of authorized representative signing this form (please print):

____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization: SILVER SAGE CENTER Name of Witness: Shila [signature]
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.