Health Questionnaire and Consent

PassportHealth

Participant Name (First)_____**(MI)**_____**(Last)**_____

If Under 18--Parent/Guardian Full Name & Phone _____
(Name) *(Phone)*

Personal Phone:_____ ○ **Mobile#** ○ **Home#** **Employer:** _____

Date of Birth: Month_____ Day_____ Year_____ **Age:** _____ **Gender:** _____

Mailing Address:_____
(Street or PO BOX) *(City)* *(State)* *(Zip)*

Email:_____

Insurance Information ***PLEASE ATTACH A COPY OF INSURANCE CARD***

1.) **Please write your** A.) **Primary Insurance** (ex: BCBS, Aetna, HealthChoice), B.) **Member ID #**, and C.) **Group # :**

A. _____ **B.** _____ **C.** _____
Insurance Company Member ID # Group #

2.) **Please include your** A.) **Secondary or Supplementary Insurance,** B.) **Member ID #,** and C.) **Group #**

A. _____ **B.** _____ **C.**_____
Insurance Company Member ID # Group #

3.) **Is Participant the primary insured?** **Yes** **No**

- **If NO, please list the Name and Date of Birth of the primary insured:**

Name: _____ **Date of Birth:** _____

Lab Services: (Covered by Insurance)
- ☐ Vital Signs
- ☐ Cholesterol Panel
- ☐ TSH (thyroid test)
- ☐ Chemistry 14 panel
- ☐ PSA (Men 50+ years)

Additional Lab Services: (Out of pocket)
- ☐ B-12 Injection $15
- ☐ Vitamin B- 12 level $20
- ☐ Vitamin D level $30
- ☐ Testosterone level $25
- ☐ Blood Type $20
- ☐ Hepatitis B titer $20
- ☐ Chickenpox titer $25
- ☐ A1C $20

Some risks of taking a blood sample include pain at needle puncture site. Other risks are redness, minor bleeding, swelling, bruising and rarely, an infection. Some people feel dizzy or faint when blood is taken.

1) **Have you had anything to eat or drink today?** **YES** **NO**

If YES, please list when you last ate or drank. _____

2) **Are you prone to fainting with blood draws?** **YES** **NO**

►I give consent for above blood tests to be drawn using venipuncture or finger stick. I understand the risks and have had the opportunity to ask questions. **Initials:** _____

I understand any results, screenings, or recommendations given to me about my health do not substitute the need for routine care with a primary care physician and should not be considered diagnostic. I authorize my health results to be recorded and released to employer, school, and/or physician if requested.

Participant Signature:_____**Date:**_____

Health History

MEDICAL HISTORY (Check all that apply)

- □ Acid Reflux/GERD
- □ Alcoholism
- □ Allergies
- □ Anemia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Cancer
- □ Chronic Pain
- □ Depression
- □ Diabetes
- □ Emphysema/Bronchitis/COPD
- □ Epilepsy/Seizure Disorder
- □ Glaucoma/Cataracts
- □ Headaches / Migraines
- □ Hearing Loss
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ GI /Bowel Disorders
- □ Kidney Disease
- □ Liver Disease
- □ Osteoporosis
- □ Skin Disorders
- □ Stroke

TOBACCO USE: Do you currently use tobacco products? □ YES □ NO

If yes, please complete the following: □ chew tobacco □ smoke tobacco

How many cigarettes do you usually smoke per day? ____ packs (1 pack = 20 cigarettes)

Would you like more information today on quitting? □ YES □ NO

CURRENT MEDICATIONS (attach list if needed)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

FAMILY HISTORY (Check all that apply)

- □ Asthma
- □ HeartDisease
- □ Stroke
- □ High Cholesterol
- □ Dementia/Alzheimer's
- □ High Blood Pressure
- □ Depression
- □ Cancer: _____
- □ Diabetes
- □ Thyroid Disease
- □ Other: _____

Primary Care Physician Information / Specialty Care Provider Information:

Please list any: _____
Name of Provider Phone Number Type of Spec

Please list any: _____
Name of Provider Phone Number Type of Spec

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Immunization Questions & Consent

Initial next to the injection(s) you consent to receive and answer the corresponding questions

_____**Flu Injection** – Answer 1-5 Only
_____**FluMist (Nasal)** – Answer 1-5 & 6-11
_____**Hep A, Hep B, and Twinrix**- Answer 1-5 & 16-17
_____**Tdap** – Answer 1-5 & 18
_____**Shingles**- Answer 1-5 & 19
_____**Vitamin B-12** – Answer 20 Only
_____**Pneumovax 23** – Answer 1-5 & 13-15
_____**Prevnar 13** – Answer 1-5 & 13-15
_____**MMR** – Answer 1-5 & 6-10, 12
_____**Meningitis** – Answer 1-5 ☐ 4 Strain ☐ B
_____**HPV** – Answer 1-5
_____**Other**

All immunizations, answer all questions in this section:	**YES**	**NO**
1. Are you sick today or have a high fever?	O	O
2. Do you have allergies to antibiotics, egg, gelatin, latex, yeast, or any vaccine ingredient?	O	O
3. Have you ever experienced a serious reaction after receiving a vaccination?	O	O
4. Have you experienced Guillain-Barre, swelling of the brain, seizure, or other nervous system problems *after* a vaccination?	O	O
5. **For Women:** Are you pregnant or trying to become pregnant?	O	O
FluMist, MMR, or Varicella answer all questions in this section:	**YES**	**NO**
6. Do you have cancer, leukemia, HIV/AIDS, or any immune system problem such as lupus, MS, rheumatoid arthritis, Chron's disease, or taking medications that suppress your immune system?	O	O
7. In the past 3 months, have you received chemotherapy, radiation, or anti-cancer medications?	O	O
8. In the past 4 weeks, have you received a cortisone, kenalog, other steroid injection, or taken prednisone or any other steroid by mouth?	O	O
9. Have you received any vaccinations in the last 4 weeks?	O	O
FluMist answer questions in this section:	**YES**	**NO**
10. In the past 48 hours have you taken antiviral medication for flu symptoms such as Tamiflu?	O	O
11. Do you have a long-term health problem with asthma, heart, lung, kidney, liver, or nervous system? Are you *younger than 18* and taking aspirin or medications containing aspirin?	O	O
MMR or Varicella answer question in this section:	**YES**	**NO**
12. During the past year, have you received a transfusion of blood or blood products?	O	O
Pneumonia (Prevnar 13 or Pnemovax 23); answer questions in this section:	**YES**	**NO**
13. Have you received a pneumonia vaccine before? **If YES, please list when (mm/yr):** _____ **Please circle which pneumonia it was: Prevnar 13 or Pneumovax 23**	O	O
14. **(18-64 years)** Do you smoke, have diabetes, asthma, COPD, other lung disease, heart disease, kidney disease, or liver disease?	O	O
15. Have you ever had a serious reaction to any vaccine containing diphtheria toxoid (e.g. Tdap?)	O	O
Hepatitis A or B, or Twinrix; answer questions in this section:	**YES**	**NO**
16. Have you **completed** the Hepatitis A or B series or the Twinrix series?	O	O
17. Are you diabetic, a first responder, or come in contact with blood or other bodily fluids such as saliva as part of work or volunteer responsibilities?	O	O
Tdap answer the following question:	**YES**	**NO**
18. Have you received a tetanus/diphtheria/pertussis (Tdap) vaccine in the last 5 - 10 years?	O	O
Shingles answer the following question	**YES**	**NO**
19. Have you received a shingles vaccine before? **If YES, please list when (mm/yr):** _____	O	O

QUESTIONS CONTINUED & SIGNATURE ON BACK

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B12 Only; answer the following question:

	YES	NO
20. Do you have an allergy to cobalamin, are pregnant, breastfeeding, history of gout, kidney disease, Leber's disease or had a serious reaction to a B12 injection in the past?	O	O

Signature and Consent

I consent to the injection(s) marked on the opposite page and have had the opportunity to ask questions and receive a Vaccine Information Sheet (VIS) for any immunizations I am receiving today. I authorize my immunization record to be recorded with the OK State Health Department and released to employer, school, and/or physician if requested.

Participant Signature:_____ **Date:**_____

Office Use Only

Vaccine	Manufacturer	Lot #	Exp Date:	Injection Site:	VIS Edition Date:
				RA LA IM SQ	
				RA LA IM SQ	
				RA LA IM SQ	
				RA LA IM SQ	
				RA LA IM SQ	

B12 Lot #:	Dose	Exp Date:	Injections Site:	Paid $:
			RA LA IM	_____ Cash / Check / CCard / No charge

Nurse provided immunization(s) to patient without difficulty and patient was observed showing no adverse reactions.

Nurse reviewed, administered injection(s), and VIS provided by:_____ **Date:**_____

Nurse NOTES: