Infectious Disease Consultants
Travelers Clinic, PLC

11211 Waples Mill Road, Suite 200
Fairfax, Virginia 22030
Phone: 703-246-9560
Fax: 703-246-9564
Website: idcdoctors.com

Patient Questionnaire

Patient Information			
Last Name:		First Name:	
Middle Initial:	Date of Birth:		Age:
Address:	City:	State:	Zip Code:
Phone:	Email:		
Health Information			
Medical Problems:			
Allergies:			
Current Medications:			

Travel Plans			
Destinations			
Country	Departure Date	Return Date	Duration
1)			
2)			
3)			
4)			
5)			
6)			

Please check all that apply:

Purpose of Trip:	☐ Business	☐ Public Health	☐ Visiting Friends/Family	☐ Tourism/Vacation
Regions Visiting:	☐ Urban	☐ Rural	☐ Beach	☐ Mountain
Accommodations:	☐ Staying with Family/Friends		☐ Lodging – Air Conditioning and/or Window Screens	
	☐ Camping (Tent)		☐ Lodging – NO Air Conditioning or Window Screens	
Activities Planned:	☐ Tour	☐ Scuba Diving	☐ Hiking	☐ Other:

Patient Signature (or, if minor, responsible party):

Today's Date:

A photocopy of this form shall be deemed as valid and effective as the original; revised 8/15/2016.

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Patient Health History

Patient Name:			
DOB:	**Today's Date:**		
		Please mark Yes or No	
1	Have you traveled to any underdeveloped countries in the past? If yes, please list:		
2	Have you ever acquired a serious illness while traveling? If yes, please explain:		
3	Have you ever taken a medication to prevent Malaria? If yes, please explain:		
4	Have you ever been ill with Traveler's Diarrhea?		
5	Have you ever taken a medication to prevent or treat Traveler's Diarrhea? If yes, please explain:		
6	Have you ever had an altitude related illness (such as mountain sickness)? If yes, please explain:		
7	Are you sick today? If yes, please explain:		
8	Do you have any chronic medical problems? If yes, please explain:		
9	Do you have allergies to medications, food, a vaccine component, or latex? If yes, please explain:		

10	Have you ever had a serious reaction after receiving a vaccination?		
11	Do you have a history of psychiatric problems, or have you been treated for psychiatric problems with medication?		
12	Do you have a history of Psoriasis?		
13	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e. diabetes), anemia, or other blood disorder? If yes, please explain:		
14	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems? If yes, please explain:		
15	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? If yes, please explain:		
16	Have you had a seizure or a brain or other nervous system problem? If yes, please explain:		
17	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, please explain:		
18	For women: Are you pregnant, or is there a change you could become pregnant during the next month?		
19	For women: Are you nursing a baby?		
20	Have you received any vaccinations in the past 4 weeks?		
21	Did you bring your immunization record card with you?		

Patient Signature:____
(or, if minor, responsible party)

Printed Name: ____

Clinic Use

Form Reviewed by: ______________________________________

Date: ____

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Patient Consent Form

______Hepatitis A	______ Yellow Fever
______Hepatitis B	______Zoster
______Hepatitis A and Hepatitis B	______Tdap
______ HIB	______Meningococcal B
______ Influenza	______ Measles/ Mumps/ Rubella
______ Meningococcal	______ Typhoid
______ Pneumococcal (PPSV23)	______ Medication to prevent Malaria
______ Pneumococcal (PCV13)	______ Medication to treat diarrhea
______ Medication to treat altitude sickness	______Other: ____________________

I, ______________________________, have read and been given a copy of the above vaccine(s) and/or medication(s) information sheet(s), and have had the opportunity to ask questions which were answered to my satisfaction. I understand the risks and benefits of this (these) vaccine(s) and/or medication(s) and request it (they) be given to me.

____
Patient Name

____
Patient Signature
(or, if Minor, Responsible Party Signature)

____
Date

Clinic Use: ______________________________

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Charges and Patient Payment Agreement

Tax ID#: 54-2004481

Patient Name:	
DOB:	**Phone Number:**

# Units	Service/Procedure	ICD10	CPT	FEE
	Consultation Fee (1-2 people)			50
	Consultation Fee (3 or more people)			75
	Immunization Administration Fee (1)			25
	Immunization Administration Fee (2 or more)			50
	Hepatitis A	Z23	90632	
	Hepatitis B	Z23	90746	
	Hepatitis A and B	Z23	90636	
	HIB	Z23	90648	
	Influenza	Z23	90682	
	Meningococcal	Z23	90734	
	Meningococcal B	Z23	90620	
	Pneumococcal (PPSV23)	Z23	90732	
	Pneumococcal (PCV13)	Z23	90670	
	Typhoid	Z23	90691	
	Yellow Fever	Z23	90717	
	Zoster	Z23	90736	
	Tdap	Z23	90715	
	Other:			
			Total Charges	
			Amount Paid	
			Payment Method	

I understand that full payment is due at the time of service. I also understand that Infectious Disease Consultants Travelers Clinic, PLC (IDC) does not participate with nor accept any insurances, and that IDC is not responsible for filing any charges to seek reimbursement from any insurance on my behalf. I may choose to submit this receipt to my insurance for reimbursement, if my health plan allows this benefit.

_______________________________ Patient Name

_______________________________ Patient Signature
(or, if Minor, Responsible Party Signature)

_______________________________ Date

Clinic Use: _______________________________

A photocopy of this form shall be deemed as valid and effective as the original; revised 9/2/2016.