Bluegrass Travel Clinic
1720 Nicholasville Road, Suite 602
Lexington, KY 40503

Initial / Subsequent

Name: _____

Depart: _____ Return: _____

Country: _____

_____

_____

Length of Stay: _____

Medical Mission Work: Yes / No

Primary Care Doctor: _____

Appt: _____ Age: _____

Account # _____

Address: _____

_____

City: _____ State: ____ Zip: _____

Phone: _____

Date of Birth: _____

SSN: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Travel Agent: _____

Other: _____

Allergies: _____

Medications: _____

_____

Personal History, Serious Illness, Injuries, and Surgeries: _____

_____

_____

Review of Systems

General: Do you have?
Fatigue ___ Weakness ___ Chills ___ Fever ___ Night Sweats ___ Weight Loss ___
If weight loss, how much? _____
_____

Head, Eye, Ear, Nose, and Throat: Do you have?
Frequent headaches ___ Trouble Swallowing ___ Ear Aches ___ Sore Throat ___ Visual Changes ___
Dental Manipulation ___

Respiratory: Do you have?
Shortness of breath ___ Chronic cough ___ Productive cough ___ Wheezing___
Blood in your sputum ___ Lung disease (COPD, Asthma, Emphysema) ___

Neurological: Do you have?
Spells of weakness of an arm or leg ___ unsteady gait ___ Seizures or convulsions ___
Numbness ___

Cardiac: Do you have?
Chest pain ___ History of a heart murmur ___ History of rheumatic fever ___

Gastrointestinal (GI): Do you have?
Nausea ___ Vomiting ___ Diarrhea ___ Heartburn ___ Loss of appetite ___ Ulcers ___
Hepatitis ___ Change in bowel habits ___ Blood in stool ___ Black tarry stools ___

GU: Do you have?
Burning when urinating ___ Blood in urine ___ Dark colored urine ___ Kidney stones ___
Prostate problems ___

Musculoskeletal: Do you have?
Joint pain ___ Joint swelling ___ Arthritis ___ Gout ___ Phlebitis of inflamed leg veins ___

Hematological: Do you have?
Anemia ___ Easy bruising ___ Easy bleeding ___ History of blood clots in your legs ____
History of blood clots in your lungs ___ Have you ever had a blood transfusion? Yes ___ No ___

Endocrine: Do you have?
Diabetes ___ How long? _____ Do you have a thyroid disorder? Yes ___ No ___
Do you take steroids? Yes ___ No ___

Skin: Do you have?
Psoriasis ___ Rashes ___ Skin changes ___ Unusual moles ___ Lumps or masses___
Ulcers or skin lesions___

Have you had? Genital or vaginal discharge ___ Ulcerations ___ Itching ___
Sexually transmitted diseases ___ HIV infection ___

Psychological: Do you have a history of?
Depression ___ Anxiety ___ Difficulty sleeping ___ Do you snore? ____
Nerve problems ____

Do you have? High blood pressure ____ Cramps in your legs when walking? ____
Poor circulation ____

Record of Vaccinations / Last Known Date

DIPTHERIA/TETANUS _____
HEPATITIS A _____
HEPATITIS B _____
MUMPS/MEASLES/RUBELLA _____
ORAL POLIO _____
MENINOCOCCAL _____
YELLOW FEVER _____
TYPHOID_____
OTHERS_____

MEDICINE	REC	ORDER	DATE	DOSE	RTE	SITE	MANF	LOT/EXP
S.C. Polio				0.5 cc			Aventis	
TD				0.5 cc			Aventis	
P.O. Typhoid				4 caps			SSVI	
Yellow Fever				0.5 cc			Aventis	
Menomune				0.5 cc			Aventis	
MMR				0.5 cc			Merck	
Hepatitis A (1)				1.0 cc			Merck	
Hepatitis A (2)				1.0 cc			Merck	
Hepatitis B (1)				1.0 cc			Merck	
Hepatitis B (2)				1.0 cc			Merck	
Hepatitis B (3)				1.0 cc			Merck	
Typhim Vi				0.5 cc			Aventis	
Tetanus (DPT)				0.5 cc			Aventis	
Japanese Encephalitis				1.0 cc			Sanofi	

Consent for Treatment

I, hereby, give my permission for Drs. Dougherty, Piercy, Meek, Rose, Rodrigue, Miedler, Kennedy, Allen and or Banks to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to my treatment being rendered. I will be given the opportunity to ask questions, and have them answered to my satisfaction. It is my responsibility to ask for clarification of any aspects of my treatment that are unclear. I understand that I may decline recommended treatment(s) at any time, but that if I choose to do so, it is at my own medical risk.

Signed:_____ **Date**:_____

Parent/Guardian