Bremo PHARMACY

Service Beyond Comparison

www.BremoRX.com

*Appointment Date/Time*_____

Travel Consultation/Consent & Insurance Form

LAST NAME	FIRST		MIDDLE INITIAL
ADDRESS	CITY	STATE	ZIP
PHONE	DATE OF BIRTH	❑ MALE	❑ FEMALE
PRIMARY CARE PHYSICIAN	EMAIL ADDRESS	HAVE A CURRENT PASSPORT? ❑ YES	❑ NO

We offer insurance billing for commercial and government prescription insurance.
Some insurance plans will cover a portion of the immunization cost. Billing does not guarantee complete coverage of the cost of the vaccines and administration fees.
Please show your ID card to the pharmacy.

Step 1: Prescreening

Please answer the following questions:

Travel plans

Travel dates:

Where are you traveling to? Include countries you will drive or travel through.

What type of lodging?

What type of activities? (Safari, mission work, working with animals etc)

Travel History: places and dates outside the U.S.

Immunization Records: Check if you have had the following

❑ Annual Flu	when:	❑ Polio	when:
❑ Hepatitis A	when:	❑ Tetanus (Tdap/TD)	when:
❑ Hepatitis B	when:	❑ Typhoid	when:
❑ Meningococcal	when:	❑ Yellow fever	when:
❑ MMR	when:	❑ Other	when:

Screener: __ST __DA __ JLH __ SM __TK __ FS __ CC __Other_____

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1. Medical Conditions (check those that apply):

☐ Asthma	☐ Hemodialysis	☐ Splenectomy/ inactive spleen
☐ Cancer	☐ Heart Disease	☐ Sickle Cell Disease
☐ Chronic Bronchitis	☐ HIV infection	☐ Terminal complement component deficiency
☐ Cirrhosis of the Liver	☐ Immune deficiency	☐ Tuberculosis (untreated)
☐ COPD	☐ Leukemia	☐ History of Shingles
☐ Congestive Heart Failure	☐ Lymphoma	
☐ Diabetes Mellitus	☐ Multiple myeloma	
☐ Emphysema	☐ Organ transplant	

Comments:

2. List Current Medications (or refer to current drug profile)

_____

_____

3. During the past 3 months, have you taken:

Oral steroids (ex-Prednisone)? ☐ Yes: ☐ > 2 weeks?_____ ☐ No

Chemotherapy? ☐ Yes _____ ☐ No

Radiation Therapy? ☐ Yes _____ ☐ No

Allergies:

4. Have you ever had a severe reaction to any vaccine, requiring medical care? ☐ Yes _____ ☐ No

5. No known drug allergies ☐ Drug allergies: (Please list)_____

6. Have you had an allergic reaction to any of the following?

eggs?	☐ Yes	☐ No	AmphotericinB?	☐ Yes	☐ No
gelatin ?	☐ Yes	☐ No	Chlortetracycline?	☐ Yes	☐ No
baker's yeast?	☐ Yes	☐ No	Albumin	☐ Yes	☐ No
neomycin?	☐ Yes	☐ No	Streptomycin?	☐ Yes	☐ No
Alum?	☐ Yes	☐ No	Polymyxin B?	☐ Yes	☐ No
Latex?	☐ Yes	☐ No	Protamine Sulfate	☐ Yes	☐ No

2-phenoxyethanol (preservative)? ☐Yes ☐ No

7. Have you received immune globulin or a blood transfusion in the past 11 months?
☐ Yes ☐ No

8. Do you have a fever, infection or other temporary illness today?
☐ Yes ☐ No

9. **Women** only:
   a. Are you pregnant? ☐ Yes ☐ No
   b. Planning pregnancy in the next three months? ☐ Yes ☐ No
   c. Are you breastfeeding? ☐ Yes ☐ No

10. Questions/Concerns regarding your travel we may be able to help you with?

_____

_____