

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

Initial / Subsequent \_\_\_\_\_ Account # \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Depart: \_\_\_\_\_ Return: \_\_\_\_\_  
Country: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Length of Stay: \_\_\_\_\_ SSN: \_\_\_\_\_  
Medical Mission Work: Yes / No Emergency Contact: \_\_\_\_\_  
Primary Care Doctor: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_  
Appt: \_\_\_\_\_ Age: \_\_\_\_\_ 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) \_\_\_

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**Neurological: Do you have?**

Spells of weakness of an arm or leg \_\_\_ unsteady gait \_\_\_ Seizures or convulsions \_\_\_  
Numbness \_\_\_

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**Cardiac: Do you have?**

Chest pain \_\_\_ History of a heart murmur \_\_\_ History of rheumatic fever \_\_\_

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**Gastrointestinal (GI): Do you have?**

Nausea \_\_\_ Vomiting \_\_\_ Diarrhea \_\_\_ Heartburn \_\_\_ Loss of appetite \_\_\_ Ulcers \_\_\_  
Hepatitis \_\_\_ Change in bowel habits \_\_\_ Blood in stool \_\_\_ Black tarry stools \_\_\_

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**GU: Do you have?**

Burning when urinating \_\_\_ Blood in urine \_\_\_ Dark colored urine \_\_\_ Kidney stones \_\_\_  
Prostate problems \_\_\_

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**Musculoskeletal: Do you have?**

Joint pain \_\_\_ Joint swelling \_\_\_ Arthritis \_\_\_ Gout \_\_\_ Phlebitis of inflamed leg veins \_\_\_

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**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 \_\_\_

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**Endocrine: Do you have?**

Diabetes \_\_\_ How long? \_\_\_\_\_ Do you have a thyroid disorder? Yes \_\_\_ No \_\_\_  
Do you take steroids? Yes \_\_\_ No \_\_\_

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**Skin: Do you have?**

Psoriasis \_\_\_ Rashes \_\_\_ Skin changes \_\_\_ Unusual moles \_\_\_ Lumps or masses \_\_\_  
Ulcers or skin lesions \_\_\_

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**Have you had?** Genital or vaginal discharge \_\_\_ Ulcerations \_\_\_ Itching \_\_\_  
Sexually transmitted diseases \_\_\_ HIV infection \_\_\_

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**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**

DIPHTHERIA/TETANUS \_\_\_\_\_  
HEPATITIS A \_\_\_\_\_  
HEPATITIS B \_\_\_\_\_  
MUMPS/MEASLES/RUBELLA \_\_\_\_\_  
ORAL POLIO \_\_\_\_\_  
MENINOCOCCAL \_\_\_\_\_  
YELLOW FEVER \_\_\_\_\_  
TYPHOID \_\_\_\_\_  
OTHERS \_\_\_\_\_

**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*