

University Health Center Travel Clinic: Let's Talk about **YOU** and your **TRIP**

The first step toward healthy travel is to share information. We need to know about you **AND** your trip so we can determine what your personal risks may be and what recommendations are best for you. Remember to bring this to your Travel Clinic appointment.

Today's Date: _____ Sex: _____

Name: _____ Date of Birth: _____

Allergies: Eggs Vaccines Meds Latex Gelatin

Other: _____

Current Medications (or provide list): _____

Departure date: _____ Return date: _____

Countries visiting: _____

Previous international travel (countries): _____

Have you ever lived in a country outside of the U.S.? Yes No

If applicable

- Pregnant or planning to get pregnant Menopausal Currently breastfeeding
 Vaginitis or yeast infections problems Last menstrual period _____

Previous immunizations

(please list dates or have your record with you)

- | | |
|---|---|
| <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> Hepatitis B _____ |
| <input type="checkbox"/> Hepatitis A/B _____ | <input type="checkbox"/> Hib _____ |
| <input type="checkbox"/> HPV _____ | <input type="checkbox"/> Influenza (month/yr) _____ |
| <input type="checkbox"/> Japanese Encephalitis _____ | <input type="checkbox"/> MMR _____ |
| <input type="checkbox"/> Meningococcal _____ | <input type="checkbox"/> Men B _____ |
| <input type="checkbox"/> Pneumococcal _____ | <input type="checkbox"/> PCV13 _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Rabies _____ |
| <input type="checkbox"/> TB Test/PPD _____ | <input type="checkbox"/> Tetanus (Td or Tdap) _____ |
| <input type="checkbox"/> Typhoid _____ | <input type="checkbox"/> Shingles (Zoster) _____ |
| <input type="checkbox"/> Varicella (Chickenpox) _____ | <input type="checkbox"/> Yellow Fever _____ |

Have you ever had or currently have any of the following?

(Please answer "yes" by checking the box)

- | | |
|--|---|
| <input type="checkbox"/> Altitude or motion sickness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding/clotting disorder | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Dengue fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting from an injection/blood drawn |
| <input type="checkbox"/> G6PD deficiency | <input type="checkbox"/> Guillain-Barré syndrome |
| <input type="checkbox"/> Hepatitis or yellow jaundice | <input type="checkbox"/> History of mental health problems |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Kidney disease/removal |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles |
| <input type="checkbox"/> MS (Multiple Sclerosis) | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Myasthenia gravis | <input type="checkbox"/> Neurological/brain disorder/infection |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Seizure/epilepsy | <input type="checkbox"/> Severe diarrhea or constipation |
| <input type="checkbox"/> Spleen removed | <input type="checkbox"/> Taking steroids now |
| <input type="checkbox"/> Thymoma | <input type="checkbox"/> Thymus gland removed |
| <input type="checkbox"/> Transfusions in past six months | <input type="checkbox"/> Transplants |
| <input type="checkbox"/> Trouble sleeping <i>(some malaria meds are not recommended if you have depression/nightmares)</i> | |

Current tobacco use

- Cigarette Cigar Chewing E-Cigarettes Hookah

Other

Do you have a history of prior surgery?

- Yes No

If yes, list surgery types and dates: _____

Do you have a medical condition that warrants maintenance medications?

- Yes No

If yes, list them here: _____