University Health Center Travel Clinic

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 outside of the U.S. for more than six months? ☐ Yes ☐ No

If yes, list each country: ____________________

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.

☐ COVID-19 ____________________

☐ Hepatitis A ____________________

☐ Hepatitis B ____________________

☐ Hepatitis A/B ____________________

☐ Hib ____________________

☐ HPV ____________________

☐ Influenza (month/yr) ____________________

☐ Japanese Encephalitis ____________________

☐ MMR ____________________

☐ Meningococcal ____________________

☐ Men B ____________________

☐ Pneumococcal ____________________

☐ PCV13 ____________________

☐ Polio ____________________

☐ Rabies ____________________

☐ TB Test/PPD ____________________

☐ Tetanus (Td or Tdap) ____________________

☐ Typhoid ____________________

☐ Shingles (Zoster) ____________________

☐ Varicella (Chickenpox) ____________________

☐ Yellow Fever ____________________

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Have you ever had or currently have any of the following?
(Please answer "yes" by checking the box)

- ☐ Altitude or motion sickness
- ☐ Asthma
- ☐ Bleeding/clotting disorder
- ☐ Cancer: ______________________
- ☐ Chickenpox
- ☐ Dengue fever
- ☐ Diabetes
- ☐ Fainting from an injection/blood drawn
- ☐ G69D deficiency
- ☐ Guillain-Barré syndrome
- ☐ Hepatitis or yellow jaundice
- ☐ History of mental health problems
- ☐ HIV
- ☐ Immune disorder
- ☐ Irritable bowel syndrome
- ☐ Kidney disease/removal
- ☐ Malaria
- ☐ Measles
- ☐ MS (Multiple Sclerosis)
- ☐ Mumps
- ☐ Myasthenia gravis
- ☐ Neurological/brain disorder/infection
- ☐ Psoriasis
- ☐ Rubella (German measles)
- ☐ Seizure/epilepsy
- ☐ Severe diarrhea or constipation
- ☐ Spleen removed
- ☐ Taking steroids now
- ☐ Thymoma (tumor of thymus gland)
- ☐ Thymus gland (inside of chest) removed
- ☐ Transfusions in past six months
- ☐ Transplants
- ☐ Trouble sleeping (some malaria meds are not recommended if you have depression/ nightmares)

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: ______________________________

Last revised: June 2021

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