University Health Center Travel Clinic Form

Remember to bring this to your travel appointment.

UNIVERSITY HEALTH CENTER
by Nebraska Medicine

Today's Date: _____

Name: _____

Date of Birth: _____ Sex: _____

Allergies: ☐ Eggs ☐ Vaccines ☐ Medication ☐ Latex ☐ Gelatin

☐ Other: _____

Current medications (or provide list): _____

_____

Departure date: _____ Return date: _____

Countries visiting: _____

Purpose of trip: _____

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: _____

What is your travel style? (check all that apply)

☐ Risk-taker ☐ Adventure seeker ☐ On the cautious side ☐ Like to eat exotic food

☐ Other: _____

What housing arrangements are you planning on?

☐ Apartment ☐ Dormitory ☐ Hotel/resort ☐ Host family ☐ Other: _____

If applicable

☐ Pregnant/planning to get pregnant ☐ Menopausal ☐ Currently breastfeeding

☐ Vaginitis or yeast infections problems ☐ Last menstrual period: _____

Previous immunizations (bring your records with you)

Did you bring your immunization record card with you?

☐ Yes ☐ No

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
- ☐ Blood transfusions in past six months
- ☐ Cancer (specify type): _____
- ☐ 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
- ☐ Organ transplant recipient
- ☐ 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
- ☐ Transplants
- ☐ Trouble sleeping

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: _____