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: ______________________

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 the 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 ☐ A little on the cautious side ☐ Other: ____________

☐ Adventure seeker ☐ Like to eat exotic food ____________

What housing arrangements are you planning on?

☐ Dormitory ☐ Apartment ☐ Other: ____________

☐ Host family ☐ Hotel/resort ____________

If applicable

☐ Pregnant or 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

It is important for you to have a personal record of your vaccinations. **If you don't have a personal record, ask your healthcare provider to give you one.** Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

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 here: ____

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