711

McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

place label here

For Office Use only

TRAVEL HISTORY FORM

Name: _____ _____
Last First

TRIP INFORMATION

Date of Departure from United States:_____ Return date/length of trip: _____

Have you traveled internationally in the past? Yes ☐ No ☐ Where? _____

_____

Do you intend to travel frequently in the future? Yes ☐ No ☐ Maybe ☐

Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:

1._____

2._____

3._____

4._____

5._____

Destination (Check all that apply): Urban ☐ Rural ☐ Remote ☐ At High Altitude ☐ Beach ☐

Is this a fixed itinerary? Yes ☐ No ☐ Unsure ☐

Purpose(s) of trip: Vacation ☐ Medical care ☐ Business ☐ Pilgrimage ☐ Education ☐ Adoption ☐
(Check all that apply) Volunteer/Humanitarian ☐ Visiting Friends/Relatives ☐ Long-stay traveler ☐

Organized tour? Yes ☐ No ☐ Partly ☐ Explain: _____

Accommodations: Hotel ☐ Hostel ☐ Staying with locals/family/friends ☐ Dorm ☐ Rented House/Apt ☐
Camping ☐ Cruise Ship/Boat ☐ Bed nets available ☐

Will you be travelling alone? Yes ☐ No ☐ If no, Explain _____

Planned Activities: *(check all that apply)* Contact with Animals ☐ Cave/spelunking ☐ Medical or dental work ☐
Water Recreation: Ocean ☐ or Fresh Water ☐ Other:_____

Allergies:

Medication(s)	Yes ☐	No ☐	If yes, list:_____
Reaction to vaccine	Yes ☐	No ☐	If yes, list:_____
Latex	Yes ☐	No ☐	If yes, list:_____
Egg or other food allergies	Yes ☐	No ☐	If yes, list:_____
Environmental (pollens, dust, hay fever, etc.)	Yes ☐	No ☐	If yes, list:_____
Animals	Yes ☐	No ☐	If yes, list: _____
Bee stings	Yes ☐	No ☐	

Have you ever experienced anaphylaxis (severe allergic reaction)? Yes ☐ No ☐

Name: _____ _____
Last First

Health History - Do you currently have or have a past history of:

Depression, anxiety, panic attacks	Yes ☐	No ☐	Close contact w/ anyone w/ immune disorder	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	History of altitude illness	Yes ☐	No ☐
Seizures or convulsions	Yes ☐	No ☐	Surgery or hospitalization in past year	Yes ☐	No ☐
Cardiac conduction defect, pacemaker	Yes ☐	No ☐	Have you ever had Hepatitis (liver infection)?	Yes ☐	No ☐
Heart disease or surgery	Yes ☐	No ☐	Has your spleen been removed?	Yes ☐	No ☐
Respiratory (lung) disease	Yes ☐	No ☐	Do you drink alcohol regularly?	Yes ☐	No ☐
Intestinal problems, heartburn, reflux	Yes ☐	No ☐	Do you smoke?	Yes ☐	No ☐
Tendonitis/Achilles' heel rupture	Yes ☐	No ☐	Other medical problem		

Immune disorder (cancer, HIV, bone marrow/organ transplant, rheumatoid arthritis treatment, inflammatory bowel disease) Yes ☐ No ☐

In the last 3 months have you taken any medications that affect your immune system (chemotherapy, prednisone, steroids, TNF blockers,other biologics?) Yes ☐ No ☐

Please explain any "yes" answers: _____

_____

_____

Medications:

Please list **all** prescribed and over-the-counter medications and supplements you use:

	Medication or supplement:	Reason for use:
1		
2		
3		
4		
5		

Women:

When was your last menstrual period?_____ Was it normal? Yes ☐ No ☐

Are you currently pregnant, trying to get pregnant or planning a pregnancy in the near future? Yes ☐ No ☐

Any risk of an unplanned pregnancy? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

What form of contraception do you use? _____

Men:

Do you have a female partner planning to become pregnant in the next 6 months? Yes ☐ No ☐

Please provide any additional information that you believe is important for us to know as you prepare for your current trip including any concerns or fears: _____

_____

_____

I have answered this questionnaire fully and to the best of my ability.

Student's signature_____ Date _____

Reviewed by:_____ RN/ NP/ PA/ MD Date _____