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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 <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Reaction to vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Latex	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Egg or other food allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Environmental (pollens, dust, hay fever, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Animals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Bee stings	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

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

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

- | | | | | | |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Depression, anxiety, panic attacks | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Close contact w/ anyone w/ immune disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | History of altitude illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Seizures or convulsions | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Surgery or hospitalization in past year | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cardiac conduction defect, pacemaker | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Have you ever had Hepatitis (liver infection)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart disease or surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Has your spleen been removed? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Respiratory (lung) disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Do you drink alcohol regularly? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Intestinal problems, heartburn, reflux | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Do you smoke? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tendonitis/Achilles' heel rupture | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other medical problem | | |
| Immune disorder (cancer, HIV, bone marrow/organ transplant, rheumatoid arthritis treatment, inflammatory bowel disease) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

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 _____