# Pre-Travel Health Assessment

Name: Telephone:

Email: Primary Care Provider:

Prior Travel History:

Date of Birth:  Gender: Country of Birth:

Destination(S):

Departure Date: Return Date: Duration of Stay:

Purpose of Travel: [ ]  Business [ ]  Vacation [ ]  Adventure [ ]  Study [ ]  Other

Accommodations (select all that apply): [ ]  Luxury Hotel [ ]  Budget Hotel [ ]  Local Home [ ]  Camping [ ]  Long Stay Apt/House [ ]  Ship [ ]  Other

Circle all that apply: [ ]  New to Travel [ ]  Urban [ ]  Rural [ ] Long Stay [ ]  VFR [ ] Frequent Flyer

 [ ] Student [ ] Traveling Alone [ ]  Traveling with a group [ ]  with Children (ages): [ ] Trekking [ ]  Altitude [ ] Scuba [ ] Rafting Cruise [ ]  Contact with Local Individuals

 [ ]  Contact with Animals [ ]  Other:

Date of last physical exam: Date of last dental exam: Last menstrual period:

Contraceptive Method(s): Pregnant (weeks): Planning Pregnancy): Lactating: Anemic:

**ALLERGIES**! None: [ ]  Vaccines: Medications: Latex: Environmental: Thimerosal: Gelatin: Eggs:

Please list all **medications** you are currently taking below:

**Significant health history** (check all that apply) [ ] History of Seizures [ ] Mental Health Problems

 [ ] History of Depression [ ] History of Psoriasis [ ] History of Heart/Cardiac Defects [ ] Heart Problems [ ] GI/stomach Issues [ ] Immunity/autoimmune problems [ ] Altitude Sickness [ ] Anemia [ ] Deep Vein thrombosis Risk [ ] other:

Surgeries:

Medical Insurance? [ ] No [ ] Yes Type:

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*PLEASE STOP HERE\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Immunization History**: Childhood vaccines complete: [ ] Yes [ ] No [ ] Don’t know PPD Date:

Tetanus/Tdap: Hep: A 1 2 Hep B: 1 2 3 Twinrix:

Influenza: Meningitis: MMR: 1 2 Pneumococcal:

Polio/IPV: Rabies: Typhoid: Varicella (VZV) 1 2

Yellow Fever: Other(s):

Malaria Drugs in the past: [ ] Atovaquone [ ] Mefloquine [ ] Doxycycline [ ] Proguanil [ ] Chloroquine [ ] Malarone [ ] Levofloxacin [ ] Acetazolamide

Reactions to any medications:

## Recommendations for your Travels:

### VACCINES:

* [ ]  Hepatitis B
* [ ]  Hepatitis A
* [ ]  Td (Tetanus)
* [ ]  Tdap
* [ ] Influenza
* [ ] Meningitis
* [ ] Polio
* [ ] Rabies
* [ ] Other

### OFF CAMPUS VACCINES

* [ ] Typhoid Injectable
* [ ] Yellow Fever

### PRESCRIPTIONS:

* [ ] Azithromycin (for TD)
* [ ] Typhoid (oral)
* [ ] Diamox (altitude sickness)
* [ ]  Other

### MALARIA PROPHYLACTIC:

* [ ] Doxycycline
* [ ] Chloroquine
* [ ] Malarone

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|  |  |
| Nurse: | Date: |

I acknowledge and understand the information I have been given

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|  |
| Print Name |

|  |  |
| --- | --- |
|  |  |
| Signature of Client | Date: |