# 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:

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**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 |

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| Signature of Client | Date: |