Please FILE in Patient's chart Student # N ________________

Pre-Travel health Assessment

Name: ____ **Telephone:** __________________

Email: ___________________ Primary Care Provider ___________________

_____ New Patient _____ Established Patient _____ Prior traveler

Date of birth: ______________ Gender: ____________ Country of Birth: _____________

Destination(s): ____

Departure Date: __________________________________ Return Date: _______________

Duration of Stay: _______________ Purpose: _______ Business ______ Vacation

__________ Adventure ___________ Study

Accommodations: ________ 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 group with Children (ages): ______
trekking Altitude scuba Rafting Cruise

Contact with local individuals Contact with Animals other _____________

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Date of last Physical Exam: __________________ Date of Last Dental Exam: ______________ Last Menstrual Period: ______________________________ Contraceptive method: __________ ______
Pregnant (weeks) _______ Planning Pregnancy________ Lactating _______ Anemic

ALLERGIES: _______ Vaccines ______ Medications _______ Latex ______ Environmental
______ Thimerosal _________ Gelatin _______ Eggs __________None known other:
_________________________ **Taking any medications please list:** ______________________

____Smoker: _____ Yes _____ No

SIGNFICANT HEALTH HISTORY: ____

______ History of Seizures ____ Mental Health Problems _____ History of Depression
____ history of Psoriasis ______ History of Cardiac Conductive Defects

Problems with: ______ **Heart** _____ **GI** _____ **Immunity**________ Surgeries

_____ Altitude Illness ____ Anemia _____ Deep vein Thrombosis rick factor ____ other

MEDICAL INURANCE? _____ NO _____ YES TYPE: ______________________

IMMUNIZATION HISTORY: Please fill in the dates on all vaccines you have received

Childhood Vaccines completed: ____ Yes ____ No ___ Don't Know PPD Date: ____

Tetanus Diphtheria: ___________ or Tdap: ____________ Hepatitis A: 1______. 2______

Hepatitis B: 1_______. 2________. 3_______ Twinrix: ________ Influenza: ________________
Meningitis: ______ MMR: _______ Pneumococcal: _______ Polio: ________ Rabies: ________

Typhoid: oral _________ injectable ____ Varicella Diagnosis 0 1______. 2________

Yellow Fever: ___________ Others: _______

Malaria Drugs in the past ______ Atovaquone ______ Mefloquine ____ Doxcycline ______ Proguanil ______ Chloroquine _____ Malarone ______ Levofloxacin ______ Acetazolamide

Please note any reactions to medications: ______________________________________

VACCINES recommended for your travels:

______ Hepatitis B

_____ Hepatitis A

______ Td (Tetanus

______ Tdap

_______ Influenza

______ Meningitis

_______ Polio

_______ Rabies

______ Other ___________

Prescriptions recommend for your travels

______ Azithromycin (for TD)

______ Typhoid (Oral)

_____ Diamox

_____ Other _______________________ _______

Malaria Prophylactic

_______ Doxycycline

_______ Chloroquine

_______ Marlarone

Off Campus Vaccines:

______ Typhoid injectable

______ Yellow Fever

NURSE: ____ DATE: ____________

I acknowledge and understand the information I have given

____

Signature of Client

____

Print Name **Date**