

## Pre-Departure Travel Consult Form

The Travel Clinic provides international travelers with information about the countries they are planning to visit, evaluates health care needs and risks, and provides immunizations and medications for travel. Students or faculty anticipating travel should make an appointment a minimum of eight (8) weeks prior to travel to allow time for any counseling and administration of immunizations.

Please fill out this form before your appointment. There is a charge for travel consultations; in addition, there may be additional charges for immunizations and medications. Several appointments may be needed. Bring your immunization records with you to your travel consultation.

### Information Regarding Travel Plans:

Date of Departure: \_\_\_/\_\_\_/\_\_\_

Return Date: \_\_\_/\_\_\_/\_\_\_

Destination (City, Country)

Type of Accommodations  
(hotel, dorm, camping, etc.)

Length of stay:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Reason for Travel: \_\_\_ Business \_\_\_ Vacation \_\_\_ Student \_\_\_ Missionary Work  
\_\_\_ Teaching \_\_\_ Volunteer Work \_\_\_ Field Work \_\_\_ Other \_\_\_\_\_

Special activities you are planning may affect decisions about travel immunizations, medications, or information appropriate for you. Please check any that apply:

Do you plan to visit only tourist's area or major cities? Yes No

Do you plan to visit rural areas? Yes No

Do you plan to go hiking or backpacking? Yes No

Do you plan to travel to high altitudes? Yes No

Do you plan to go swimming? Yes No

If yes: Chlorinated Pool Ocean Fresh water lake or stream

Do you plan to scuba dive? Yes No Certified? \_\_\_\_\_  
If yes: When is air travel scheduled after the first dive? \_\_\_\_\_

Do you plan to do cave exploration? Yes No

Do you plan to deliver health care or work in an orphanage? Yes No

Do you plan to work with animals? Yes No

## Medication and Allergy Information

List Current Medications (including oral contraceptives, over-the-counter medications, herbals, vitamins): \_\_\_\_\_

Please check if allergic to any of the following medications: \_\_\_ Neomycin \_\_\_ Penicillin  
\_\_\_ Gentamycin \_\_\_ Sulfa \_\_\_ Streptomycin \_\_\_ Polymixin \_\_\_ Amphotercin B  
\_\_\_ Other: \_\_\_\_\_

Please check if allergic to any of the following vaccine components: \_\_\_ thimersol/mercury  
\_\_\_ phenol \_\_\_ aluminum hydroxide \_\_\_ 2-phenoxyethanol \_\_\_ formaldehyde  
\_\_\_ aluminum \_\_\_ chlortetracycline \_\_\_ other: \_\_\_\_\_

Please check if allergic to any of the following: \_\_\_ eggs \_\_\_ yeast \_\_\_ gelatin \_\_\_ latex  
\_\_\_ animal protein \_\_\_ feathers \_\_\_ bee stings \_\_\_ lactose \_\_\_ nuts  
\_\_\_ others: \_\_\_\_\_

## Medical History

Do you have a medical condition that warrants regular medication or physician follow-up?  
Yes No  
If yes, please list: \_\_\_\_\_

Do you have heart problems? Do you have a cardiac arrhythmia or irregularity? Yes No

Do you have high blood pressure? Yes No  
If yes, are you on medication? Yes No

Do you have bleeding or clotting problems; take Coumadin, anticoagulants, or aspirin? Yes No

Have you had surgery in the past three months? Yes No  
If yes, describe: \_\_\_\_\_

Do you have lung disease, asthma, chronic bronchitis, emphysema, or shortness of breath? Yes No

Do you have a stomach or bowel condition, such as irritable bowel or frequent constipation or diarrhea? Do you use medication to reduce stomach acid daily? Yes No

Do you have any skin conditions such as psoriasis, eczema, or shingles? Yes No

Do you experience insomnia or nightmares? Yes No

Do you have diabetes? Yes No

If yes, do you use insulin? Yes No

Do you have tuberculosis? Have you ever tested positive for tuberculosis? Yes No

When at altitudes above 6,000 feet have you ever had headache, dizziness, or felt short of breath?  
Yes No

Have you had hives or urticaria? Yes No

Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy, or radiation therapy? Yes No

Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS or any other auto immune disease? Yes No

Do you have severe kidney problems? Yes No

Do you have G6PD deficiency? Yes No

Do you have an active nerve condition? Do you have a history of Guillian-Barre syndrome? Yes No

Have you had your thymus gland removed, or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome or thymoma? Yes No

Do you have a history of depression, panic disorder or other psychiatric disorder? Yes No

Do you have a history of an eating disorder? Yes No

Have you received any vaccinations in the past 4 weeks? Yes No

If yes, list: \_\_\_\_\_

Have you ever had a serious reaction after receiving a vaccination, such as hives, rash, wheezing, difficulty breathing, or shock? Yes No

If yes, describe reaction: \_\_\_\_\_

Do you have any dental problems? Yes No

Do you wear corrective lenses? Yes No

Women only - Are you pregnant or do you plan to get pregnant in the next 3 months? Yes No

## Previous Immunizations

Please list the country of your birth: \_\_\_\_\_

Please bring your immunizations records with you to your appointment.

Please indicate the immunizations you have received and dates:

Twin Rix (Hepatitis A and B vaccine): #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Hepatitis A Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Hepatitis B Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

MMR: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Polio: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Tetanus/Diphtheria/Pertussis: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Tetanus Booster (Td or Tdap): \_\_\_\_\_

Varicella: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Influenza Vaccine: \_\_\_\_\_

Meningococcal: \_\_\_\_\_

Pneumococcal: \_\_\_\_\_

TB skin test: \_\_\_\_\_

Typhoid Injection: \_\_\_\_\_

Typhoid Oral Capsules: \_\_\_\_\_

Yellow Fever Vaccine: \_\_\_\_\_

Rabies Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Japanese Encephalitis Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_