

TRAVELER HISTORY FORM

Once this completed form and immunizations are received, a student health representative will contact you to schedule an appointment with our travel clinic. Please allow time for staff to review.

PATIENT INFORMATION		DATE:
Patient Name (Last, First, Middle, Maiden):		
Current Address (include City, State, Zip):		
University ID#	Date of Birth (MM/DD/YYYY):	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	<input type="checkbox"/> Student <input type="checkbox"/> Other: _____	
Phone #:	Email Address:	
TRAVEL PLANS (LIST ADDITIONAL INFORMATION ON BACK OF FORM IF NEEDED):		
Purpose of trip (check all that apply):		
<input type="checkbox"/> Vacation <input type="checkbox"/> Research <input type="checkbox"/> ISU Study Abroad <input type="checkbox"/> Visit Friends or Family <input type="checkbox"/> Missionary/volunteer/humanitarian relief <input type="checkbox"/> Work (urban, office-based or conference) <input type="checkbox"/> Work (rural, outdoors or in local community) <input type="checkbox"/> Other: _____		
Planned activities (list all):		
Will you be:		
Visiting areas that are: Rural <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Urban <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure/ Primitive or remote <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Ascending to high altitudes (8,000 ft or higher)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Working with potential exposure to body fluids (ie. medical or dental work)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Working with exposure to animals? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Potentially having new sexual partners? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure		
Accommodations (check all that apply):		
<input type="checkbox"/> Resort/large hotel <input type="checkbox"/> Small hotel/guest house/B&B <input type="checkbox"/> Cruise Ship <input type="checkbox"/> Private home (with locals) <input type="checkbox"/> Private home (with relatives) <input type="checkbox"/> Private home (expatriate or high-end) <input type="checkbox"/> Primitive camping <input type="checkbox"/> Up-scale camp/lodge <input type="checkbox"/> Dormitory/hostel <input type="checkbox"/> Other: _____		
Previous international travel (year/destination)/Previous use of anti-malaria medication (year/destination):		

COUNTRIES AND CITIES IN ORDER OF VISIT	ARRIVAL DATE	DEPARTURE DATE

HEALTH HISTORY (Check all that apply)

<p>ALLERGIES</p> <input type="checkbox"/> Antibiotics (ie. penicillin, sulfa): _____ <input type="checkbox"/> Other medications: _____ <input type="checkbox"/> Egg <input type="checkbox"/> Latex <input type="checkbox"/> Gelatin <input type="checkbox"/> Yeast <input type="checkbox"/> Bees/wasps <input type="checkbox"/> Seasonal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Side effects/reactions from previous medications (ie. nausea, dizziness, stomach upset): _____	<p>IMMUNE SYSTEM</p> <input type="checkbox"/> Steroids by mouth within last 3 months <input type="checkbox"/> Immune suppressive medications or treatments within last 3 months (ie. radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab) <input type="checkbox"/> Spleen removed <input type="checkbox"/> Thymus disease or thymectomy <input type="checkbox"/> HIV/AIDS • Most recent CD4: _____ • Most recent viral load: _____ <input type="checkbox"/> Organ, bone marrow, stem cell transplant _____ <input type="checkbox"/> Other: _____
<p>CANCERS/BLOOD DISORDER</p> <input type="checkbox"/> Coagulation disorder/blood clots <input type="checkbox"/> History of cancer or blood disorder <input type="checkbox"/> Other: _____	<p>KIDNEYS</p> <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney insufficiency <input type="checkbox"/> Other: _____
<p>CARDIOVASCULAR</p> <input type="checkbox"/> Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block) <input type="checkbox"/> Implanted pacemaker or automatic defibrillator <input type="checkbox"/> Heart attack <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____	<p>LUNGS</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Other: _____
<p>ENDOCRINE</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Other: _____	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> RA <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Other: _____
<p>GI</p> <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> IBS <input type="checkbox"/> GERD <input type="checkbox"/> Chronic hepatitis <input type="checkbox"/> Cirrhosis or liver failure <input type="checkbox"/> Other: _____	<p>NEUROLOGIC/PSYCHIATRIC</p> <input type="checkbox"/> Seizure or epilepsy <input type="checkbox"/> Anxiety/depression <input type="checkbox"/> History of Guillain-Barré <input type="checkbox"/> Other: _____
<p>HEENT</p> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other: _____	<p>SKIN</p> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____
	<p>OB/GYN</p> <input type="checkbox"/> Pregnant: _____ weeks/trimester <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Possible pregnancy in next 3 months <input type="checkbox"/> Other: _____

VACCINATION HISTORY (Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

COVID-19	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Hepatitis A	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Hepatitis B	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Meningococcal	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Measles/Mumps/Rubella	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Polio	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Tetanus	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Typhoid	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Yellow Fever	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Japanese Encephalitis	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Influenza	<input type="checkbox"/> Yes, When _____	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Other: _____			

Have you ever had an adverse reaction to an immunization? No Yes Explain: _____

