Place label here

International Travel Health History

_ Registered student _ Faculty/Staff _ Other

Email: ____

Allergy History

Do you have any allergies?	_ Yes	_ No

If yes, please describe type of reaction below:

Medication (esp. neomycin, streptomycin, cortisone, steroids, quinolone, Malarone, oral typhoid, tetracycline, rifampin, rifabutin, metoclopramide, beta blockers):

____

Environmental: ____

Bee or wasp sting: ____

Food (esp. eggs, Baker's yeast, milk, gelatin-containing products):

____

Are you allergic to thimerisol (a preservative in vaccines)?	_ Yes	_ No
Have you ever had an adverse reaction to a vaccine?	_ Yes	_ No
Which vaccine(s)? ______________________________		
Do you have an allergy to dry natural rubber latex?	_ Yes	_ No

Current Health

What is your age? _______

Do you presently have an illness, with or without fever?	_ Yes	_ No
If female, are you currently pregnant or a nursing mother?	_ Yes	_ No
Do you plan to become pregnant in the next three months?	_ Yes	_ No

Medical History

Please check all applicable conditions below and explain. If you have a chronic illness (diabetes, cancer, liver, kidney, or gastrointestinal disease, HIV infection), consult your MD before receiving any immunizations.

_ skin disease, eczema____

_ hay fever____

_ back problem ____

_ psychiatric disorder/depression/anxiety __________________________________

_ eating disorder ____

_ digestive tract problem ____

_ seizure disorder, epilepsy ____

_ headaches (frequent/severe)____

_ high blood pressure ____

_ heart problem ____

_ jaundice/liver disease____

_ lung disease ____

_ cancer, leukemia ____

_ diabetes ____

_ blood disorder/bleeding disorder ____

_ urinary tract problem/kidney disease _____________________________________

_ eye disease (other than near-sightedness or astigmatism) _______________________

_ immunosuppressed or receiving immunosuppressive therapy/radiation or chemo- therapy

____

Place label here

Have you received either gamma globulin or a blood transfusion in the last five months?
_ Yes _ No

Medications
Please list all medications that you take regularly. Include vitamins, non-prescriptions, oral contraceptives.
Prescription medication: ______
Non-prescription medication: ______
Oral contraceptive: ______
Other (specify): ______

Previous Immunizations
Please list dates for those immunizations you have received BRING ALL RECORDS.
Hepatitis A: #1 ______ #2 ______
Hepatitis B: #1 ______ #2 ______ #3 ______
Japanese Encephalitis: ______
MMR: ______
Meningococcal: ______
Polio: ______
Rabies: ______
Tetanus: ______
Typhoid: oral or injectable? ______
Yellow Fever: ______
Varicella (chicken pox): ______

Trip Details
Departure date: ______ Return date: ______
Anticipated travel conditions (check all that apply)
_ organized group travel
_ independent travel
_ camping
_ first class hotel
_ university dorm/youth hostel
_ private home
_ working in contact with animals or doing field work (specify): ______
_ high altitude (specify location, elevation, and duration): ______
_ performing tasks requiring fine coordination and spatial discrimination (such as piloting an airplane)
_ other: ______

Itinerary
Please list the countries you plan to visit in chronological order with an estimated duration of stay in each country. Star (*) any countries in which you plan to camp or stay outside the major urban areas.

country	est. duration	country	est. duration
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	