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 ___________________________________________________________

9/16/05
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 _ first class hotel
_ independent travel _ university dorm/youth hostel
_ camping _ 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.

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