The University of Puget Sound

Counseling, Health and Wellness Services

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Travel History Form

Name:_____ Student I.D.No._____

Address:_____

Todays Date:_____/_____/_____Date of Birth: _____/_____/_____

Male:_____ Female:_____

Home Telephone No.: (_____)_____ Cell Phone: (_____)_____

E-mail Address:_____

Do you have a current passport or visa? Yes:___ No: ___ Don't Know:___

Travel Specifics

Purpose of Trip

School Related Study/Work: ___ What School?:_____

Pleasure:___ Business:___ Other:___

What will you be doing on this trip? _____

_____

Does your program require the completion of a medical form by a practitioner?

Yes:___ No:___

Are you currently enrolled in a health insurance plan that covers you while overseas? Yes:___ No:___

What insurance coverage do you currently have?_____

Departure Date from United States:_____

Return Date to United States:_____

Countries AND cities to be visited in order of visits	Arrival Date	Departure Date

A. Have you traveled outside the United States before? Yes:___ No:___

If yes. where and when?: _____

Name:_____ Student I.D.No._____

B. Will you be:

YES	NO	
		Visiting ONLY urban areas? If no, explain:_____ _____
		Staying ONLY in Hotels? If no, explain:_____ _____
		Visiting friends and family?
		Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains.
		Working in the medical or dental field with exposure to blood or other body fluids?
		Working with exposure to animals?
		Potentially having sexual contact with new partners?

Allergies

1. No known drug allergies?:_____ No known Food allergies?:_____

2. Have you had an allergic reaction to any of the following? (please check all that apply)

___ Eggs

___ Sulfa Drugs (e.g., Bactrim, Septra, Gantrisin)

___ Antibiotics (e.g., Neomycin, Streptomycin)

___ Thirnerosal (preservative in contact lens solution)

___ Chrysanthemums

___ Quinines (Chloroqulne [Aralen], Mefloqulne [Lariam], Hydroxycholoroqulne [Plaquenil], Primaqulne)

___ Pyrimethamine

___ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin)

Other:_____ _____

Immunizations

1. Were you born in the United States? Yes:___ No:___

If no, where?_____

2. Have you completed the following immunizations?

Hepatitis A	Yes:___ when: _____	No: ___	Not Sure:___
Hepatitis B	Yes:___ when: _____	No: ___	Not Sure:___
Meningococcal Meningitis	Yes:___ when: _____	No: ___	Not Sure:___
MMR (Measles, Mum and Rubela)	Yes:___ when: _____	No: ___	Not Sure:___
Polio Series	Yes:___ when: _____	No: ___	Not Sure:___
Tetanus	Yes:___ when: _____	No: ___	Not Sure:___
Typhoid	Yes:___ when: _____	No: ___	Not Sure:___
Yellow Fever	Yes:___ when: _____	No: ___	Not Sure:___

Other:_____ when:_____

Name:_____ Student I.D.No._____

Medical History

1. Are you using steroids, receiving radiation therapy or other Immunosuppressive chemotherapy? Yes:___ No:___

2. List your current prescription medications and medical condition treated: (Include birth control pills)

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

3. List regularly used non-prescription medication (over-the-counter, herbal, homeopathic, vitamins, etc.)

Regularly Used Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

4. Have you been told you have any of the following medical conditions(check all that apply)?

Yes	No	Family History		Yes	No	Family History		Yes	No	Family History	
			Anemia				G6PD Deficiency				Liver Disease/Hepatitis
			Asthma				Gout				Lung Disease
			Blood Clotting Problems				Hearing Problem				Prostate Problemss
			Cancer				Heart Disease				Psoriasis/Other Skin Problem
			Depression				High Blood Pressure				Psychiatric Problems
			Diabetes				High Cholesterol				Sickle Cell Disease
			Ear Infections Chronic or Frequent				Hormone Problems				Stomach Ulcer
			Epilepsy/Seizure Disorder				Immune System Deficiency				Stroke
			Eye Problems				Kidney Disease				Thyroid Problems
											Other:

5. **(For Women Only)**

a. Last normal menstrual period:_____

b. Are you, or could you possibly be, pregnant? Yes:___ No: ___

c. Are you breast-feeding an Infant? Yes:___ No: ___

Questions/Concerns

1. Please list additional questions or concerns that you might have regarding your travel? (i.e., Int'l, voltage requirements, currency exchange, dealing with seasickness, etc.) _____

_____

_____ Rev: 2003