TRAVEL MEDICAL HISTORY QUESTIONNAIRE

SAINT XAVIER UNIVERSITY HEALTH CENTER
3925 W. 103rd Street Chicago, IL 60655
Phone: (773) 298-3712 Fax: (773) 298-3906

Name:	Today's Date:

Country of Birth:	Gender:	Date of Birth	Age:

If you have insurance, does your insurance cover:
Health care overseas? □ Yes □ No □ Not sure
Medical evacuation? □ Yes □ No □ Not sure

TRAVEL PLANS

COUNTRIES AND CITIES IN ORDER OF VISIT Please list in the order you will be traveling, INCLUDING LAYOVERS	**ARRIVAL DATE**	**DEPARTURE DATE**
1.		
2.		
3.		
4.		
5.		

TRIP INFORMATION

TRIP PURPOSE:
(check all that apply)

□ Vacation
□ Education/research
□ Missionary/volunteer/humanitarian relief
□ Visiting friends or family
□ Safari
□ Cruise
□ Adoption
□ Work (urban, office-based, or conference)
□ Work (rural, outdoors, or in local community)
□ To obtain medical or dental care

ACCOMODATIONS:
(check all that apply)

□ Resort/large hotel
□ Small hotel/guest house/B&B
□ Cruise ship
□ Private home (with locals)
□ Private home (with relatives)
□ Primitive camping
□ Upscale camp/lodge
□ Dormitory/hostel
□ Other:

PLANNED ACTIVITIES (list all):

Will you be:

- Visiting areas that are:
  - Rural □ Yes □ No □ Not sure
  - Urban □ Yes □ No □ Not sure
  - Primitive or remote □ Yes □ No □ Not sure

- Ascending to high altitudes (8,000 ft or higher?) □ Yes □ No □ Not sure
- Working with potential exposure to body fluids (i.e. medical or dental work)? □ Yes □ No □ Not sure
- Working with exposure to animals? □ Yes □ No □ Not sure
- Potentially having new sex partners? □ Yes □ No □ Not sure

HEALTH HISTORY (check all that apply)

ALLERGIES
□ Antibiotics (e.g. penicillin, sulfa) _____
□ Other medication(s): _____
□ Egg □ Gelatin
□ Latex □ Yeast
□ Bees/wasps
□ Seasonal
□ Other_____
□ Side effects/reactions from previous medications (i.e. nausea, dizziness, stomach upset): _____
_____

CANCERS/BLOOD DISORDERS
□ Coagulation (clotting) disorder
□ History of cancer or blood disorder
□ Other_____

CARDIOVASCULAR
□ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
□ Implanted pacemaker or automatic defibrillator
□ Heart Attack
□ High cholesterol
□ High blood pressure
□ Stroke
□ Other_____

LUNGS
□ Asthma
□ Emphysema/COPD
□ Other_____

ENDOCRINE
□ Diabetes
□ Thyroid disease
□ Other

GI
□ Crohn's disease or ulcerative colitis
□ IBS
□ GERD
□ Chronic hepatitis
□ Cirrhosis or liver failure
□ Other_____

KIDNEYS
□ Dialysis
□ Kidney insufficiency
□ Other_____

SURGERY
Have you ever had any surgeries? □ Yes □ No
If yes, what kind? _____
_____
_____
_____

IMMUNE SYSTEM
□ Steroids by mouth within the last 3 months
□ Immune suppressive medications or treatments with the last 3 months (i.e. radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
□ Spleen removed
□ Thymus disease or thymectomy
□ HIV/AIDS
Most recent CD4:_____
Most recent viral load:_____
□ Organ, bone marrow, stem cell transplant_____
□ Other_____

MUSCULOSKELETAL
□ Rheumatoid arthritis
□ Psoriatic arthritis
□ Other_____

NEUROLOGIC/PSYCHIATRIC
□ Seizures or epilepsy
□ Anxiety/Depression
□ History of Guillain-Barre
□ Other_____

SKIN
□ Psoriasis
□ Other_____

OB/GYN
□ Pregnant: _____weeks/trimester
□ Breastfeeding
□ Possible pregnancy in the next 3 months
□ Other_____

NAME:	DOB:

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

Have you ever had any of the following vaccinations?

Hepatitis A (2 doses)	□ Yes When?_____ □ No □ Not Sure
Hepatitis B (3 doses)	□ Yes When?_____ □ No □ Not Sure
Meningococcal conjugate (meningitis) (Menactra or Menveo)	□ Yes When?_____ □ No □ Not Sure
Measles/Mumps/Rubella (MMR) (2 doses)	□ Yes When?_____ □ No □ Not Sure
Polio (3 or more doses, one being after the 4th birthday)	□ Yes When?_____ □ No □ Not Sure
Tetanus-diphtheria (Td)	□ Yes When?_____ □ No □ Not Sure
Tetanus-diphtheria with pertussis (Tdap)	□ Yes When?_____ □ No □ Not Sure
Varicella (Chicken pox) (2 doses)	□ Yes When?_____ □ No □ Not Sure
Typhoid (□ oral or □ injectable)	□ Yes When?_____ □ No □ Not Sure
Yellow Fever	□ Yes When?_____ □ No □ Not Sure
Japanese Encephalitis	□ Yes When?_____ □ No □ Not Sure
Influenza	□ Yes When?_____ □ No □ Not Sure

Other:

Have you ever had an adverse reaction to an immunization? □ No □ Yes
If yes, please explain:

COMMUNICABLE DISEASE HISTORY

Have you ever had any of the following communicable diseases? If yes, please write in the approximate date.

□ Chicken Pox_____ □ Measles_____ □ Mumps_____
□ Rubella_____ □ Hepatitis A_____ □ Other_____

□ None of these

CURRENT MEDICATIONS	
Prescription medications: List all current prescription medications (continue on back if needed)	
Medication	**Reason for use/medical condition**
1.	
2.	
3.	
4.	
5.	
Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.	
Products	**Reason for use/medical condition**
1.	
2.	
3.	
4.	
PREVIOUS TRAVEL	
Please list any previous international travel (year/destination):	
QUESTIONS/CONCERNS	
Additional questions or concerns about your travel:	

I certify that the above information is complete and accurate to the best of my knowledge. I hereby consent to a travel vaccine consultation. I understand that certain travel vaccines may not be covered by insurance and that this will be discussed before any are administered. I understand that certain travel vaccines may not be kept in stock at the SXU Health Center, and will need to be prepaid and ordered for administration at a later date.

Traveler signature_____ Date_____

Parent/guardian signature (if traveler under age of 18)_____