

International Travel Questionnaire

The answers you supply in this questionnaire will enable us to give the most accurate medical information and advice for your specific travel plans. Please fill this out completely prior to your travel appointment. The more details you can provide regarding your itinerary, the better we can prepare you for a safe and healthy travel experience. Please bring with you, or verify, that we have a copy of your immunization records.

Name: Phone #: Main Country of Stay:		DOB:			Student ID#:			
		Country of Birth:			Email	Email Address:		
		Departure Date:			Return Date:			
1.	What is the purpose of yo	purpose of your travel? (Study abroad, vacation, volunteer, medical mission, etc.)						
2.	Please list all the countries, in order of travel, that you will be visiting, or consider visiting:							
	1. Country	y Region/Cities			Travel		tion	
	2. Country	Region	n/Cities		Trav	vel Date/Durat	tion	
	3. Country Region/Cities		n/Cities		Trav	vel Date/Durat	tion	
	4. Country	Region/Cities		Travel I		vel Date/Durat	tion	
	5. Country	Region	n/Cities		Trav	vel Date/Durat	ion	
	or travels to multiple dest ng it to your appointmen		parate shee	et of paper.	If you have a spec	ific itinerary	with travel dates, please	
3.	What is your living situat	ion going to be? (Hor	ne stay, dor	m, hostel/ho	tel, camping, etc)		
4.	Please list all planned and possible activities (backpacking, hiking, high altitudes, scuba diving, etc)							
5.	Travel Style: Independent Package Tour Adventure trip							
6.	Are you visiting friends a	nd relatives?	No	Yes				
7.	Do you have any health c	oncerns regarding you	ur travel? _					
8.	Have you have any medical or psychiatric problems? No Yes, please explain:							
9.	Is there any chance you c	ould be pregnant?	No	Yes N	J/A			
	Do you smoke? No							
	Do you have any allergies				-			
	What regular medications							
	List any previous travel e				tes:			
	Have you taken Malaria r			Yes				
	Have you taken Travelers			No	Yes			
	Do you have problems with	-	No	Yes				
	Have you had any other i	-		No	Yes, please exp	olain:		
	Do you have a form that i		-	No				
19.	Are you currently enrolle	d in a health insurance	e plan that c	covers you w	while overseas?	No	Yes	
20.	Do you have a current pas	ssport or visa?	No	Yes				
Ap	pointment Date:		Time:					

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For Health Center Staff Only

Immunization History

Please attach a copy of immunization record

Hepatitis A	#1	#2		
Hepatitis B	#1	#2	#3	#4
Twinrix	#1	#2	#3	#4
HPV	#1	#2	#3	
Influenza				
Japanese Ence	phalitis #1	#2		
MMR	#1	#2		
Meningococca	ıl			
Polio				
PPD (placed)		(Read)		
Rabies	#1	#2	#3	
Tdap/Td				
Typhoid (oral)		Injectable:		
Varicella	#1	#2		
Yellow Fever		Other		

Nursing Notes