UofL Campus Health Services Travel Medicine

Foreign Travel Questionnaire

Belknap: phone: (502)852-6479 fax: (502)852-0660
HSC: phone: (502)852-6446 fax: (502)852-6649

You must complete and return this form to Campus Health **BEFORE** your scheduled visit.

Name: _____ Date of Birth: _____

Address: _____ _Student/Employee ID# _____

_____ Phone: _____

TRIP/ITINERARY INFORMATION:

I am traveling □ on my own

□ with a non-UofL program: _____(Please specify)

□ with a UofL sponsored group: Trip Leader/Planner: _____

Trip Name/Destination: _____

Trip Details/Itinerary:

Date of departure: ____/____/____ Date of Return: ____/_____/____

List all cities, regions, and countries to which you will travel in the order of travel:

(We must know all cities and side trips in order to determine immunization and medication needs. Include all non-US cities in which your plane will stop during transit.)

CITY/REGION, COUNTRY	**LENGTH OF STAY**

CHECK ALL THAT APPLY IN EACH SECTION:

AREAS VISITING:	**STAYING IN:**	**ACTIVITIES:**	
□ Urban	**□ Dorm/residence hall**	**□ Studying**	**□ Medical/dental work**
□ Rural	**□ Hotel/hostel**	**□ Relief work**	**□ Vacation**
□ Remote	**□ National home/friend's home**	**□ Visiting family/friend**	**□ High altitude (>5000 feet)**
□ Unsure	**□ Camping**	**□ Hiking/climbing**	**□ Rafting**
	□ Other _____	**□ Scuba/snorkeling**	**□ Caving**

Do you have any medical conditions or concerns that you'd like to discuss in relation to travel?

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Patient Name:_____ Date of Birth:_____

ALLERGIES: □ No known allergies

□ **Food** (Specify): _____**If yes→** Do you carry an Epi-pen? □ Yes □ No

□ **Medication (specify) _____ Reaction:_____**

□ **Medication (specify) _____ Reaction:_____**

□ **Bee stings: If yes→** Do you carry an Epi-pen? □ Yes □ No

MEDICAL CONDITIONS:

□ Asthma	□ High blood pressure	□ Respiratory/lung problem
□ Blood/clotting disorder	□ Immune deficiency	□ Seizures
□ Cancer	□ Insomnia	□ Skin problems
□ Depression/anxiety	□ Kidney/bladder problem	□ Steroid therapy (current)
□ Diabetes	□ Liver problem	□ Stomach/intestinal problem
□ Ear problem	□ Mental health history	□ Thyroid problem
□ Eye/vision problem	□ Photosensitivity	□ Other
□ Heart condition	□ Pregnant/nursing	□ Other

CURRENT MEDICATIONS (Include prescription, over the counter, and supplements):

HOSPITALIZATIONS/SURGERIES	**DATE**

FEMALES ONLY: Date of last menstrual period: __/__/__ □ I am or could be pregnant.

Current method of birth control: _____

I attest that the above information is accurate and complete to the best of my knowledge. I understand that, because of my participation in this trip and travel medicine appointment, I will be advised by a healthcare provider affiliated with the University of Louisville's Campus Health Services as to the required and/ or recommended immunizations, medications, and travel precautions for my trip. It is my responsibility to comply with their recommendations. I understand that refusing recommended medications or immunizations could result in serious medical illness. I understand that this consultation does not represent a medical clearance for travel. I will not hold the University of Louisville or Campus Health Services responsible should I contract illnesses or suffer injury associated with this trip.

Student Signature: _____ **Date:** ___/___/___