Connecticut College Student Health Services
Pre-Travel Health Questionnaire

Personal details

Name: _____ Date of Birth: _____ Male / Female

Class Year: _____ Weight _____ Allergies:_____

Contact telephone number: _____ Email: _____

Date of Initial Departure: _____ Final Return date or length of trip: _____

Itinerary and purpose of visit Length of stay

List all countries and travel dates in order of dates travelling:	*FROM:*	*TO:*
1.		
2.		
3.		

Please check as appropriate below to best describe your trip Reason for travel	Student		Tourist		Missionary/Other	
2. Trip type	Study Abroad		Self organized		Tour group	
	Camping		Enter rivers/ponds		Trekking	
3. Accommodation	Hotel		Family home		Hostel/Other	
4. Travelling	Alone		With family/friend		In a group	
5. Staying in area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	
7. Food preferences	Adventurous		Conservative		Special diet	

Medications: *(List all medications you take routinely, and "as needed" for illnesses)*

Drug Name	Dosage strength	Frequency of use	Reason for use

Health History Questions

Questions	Yes	No	Questions	Yes	No
Do you have a medical condition that warrants maintenance medication or physician follow-up? If yes, please list.			Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy?		

Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?			**Do you or any person you are in close contact with have cancer, leukemia, HIV/AIDS, or other auto immune system problems?**		
Do you have high blood pressure?			**Do you have kidney problems?**		
Do you have any bleeding problems; take aspirin, or other blood thinner medication?			**Do you have a G6PD deficiency?**		
Do you have a history of clotting disorders? (Stroke, heart attack, pulmonary embolus, etc)			**Do you smoke cigarettes? If so, how much?**		
Do you have lung disease, asthma, or shortness of breath?			**Do you have a history of seizures or Guillian-Barre Syndrome?**		
Do you have a stomach or bowel condition such as bowel irritability, frequent diarrhea or constipation, heartburn or ulcer?			**Do you have any skin conditions such as psoriasis, eczema or shingles?**		
Have you ever been treated for depression, anxiety or other psychiatric illness?			**Have you received any vaccinations in the past 4 weeks? Please list:**		
Have you ever attempted suicide or had suicidal thoughts?			**Are you prone to motion sickness?**		
Do you have diabetes? If so do you take insulin?			**Have you ever had a serious reaction such as hives, rash, wheezing, difficulty breathing, or shock after receiving a vaccination? If so, describe:**		
Have you ever tested positive for tuberculosis? If so, describe your treatment:			**Have you had any medical problems occur during previous travel? If so, describe**		
			WOMEN ONLY: Are you pregnant, or planning to get pregnant in the next 3 months?		
			Please share any other pertinent medical information that may impact your travel:		

MD/APRN Notes:

FOR MD/APRN/RN OFFICIAL USE:

DATE: Travel risk assessment performed on:

Travel vaccines recommended for this trip

Disease protection	Date of Last Dose(s)	Recommended by the CDC	Required by Country	Patient declined	Dosage info: Lot#/Exp. Date/IM-SQ/ site
Td/DTP/DT (Tetanus/Diptheria)					
MMR					
Polio					
Hepatitis A					
Hepatitis B					
Typhoid					
Influenza B					

Influenza A (H1N1)					
Meningococcus					
Varicella					
Yellow Fever					
Japanese Encephalitis					
Rabies					
Other					

Next vaccine dose required by:_____

Travel instructions and written information given on the following topics:

Food water and personal hygiene advice		Travellers diarrhea precaution and treatment		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Travel Insurance		Air travel/DVT		Sun and heat protection	
Websites: *www.cdc.gov/travel*		Travel Record card supplied		STD protection	
Emergency health care access		Other:		Birth Control	

MALARIA RISK? _____***Yes*** _____***No***

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Malaria Medication: Start Date:_____ Stop Date:_____

Other Medication for Trip:

Traveler's Diarrhea: (Cipro, Pepto Bismol, Immodium) _____

Other:

Post trip PPD 12 weeks after return from endemic area: Due:_____

Consult by: _____ Date: _____