Iowa State University Thielen Student Health Center
Phone 515-294-5801 Fax 515-294-5892

Patient Name _____ ISU ID # _____

YES ☐ NO ☐ Are you required to have a physical examination/statement of health before you travel?
(as directed by the Study Abroad Office or other coordinating office?)

International Travel Questionnaire

Date of Birth:_____ Sex: Male ☐ Female ☐

Student ☐ Faculty/Staff ☐ Other ☐

Primary Phone #: _____ Local Address: _____

Today's Date: _____ Work or Cell Phone #: _____

Date of Departure: _____ Date of Return: _____ Purpose of Travel: _____

Destination Country or Countries (Please list all): _____ _____ _____

Check all that apply: Travel with group ☐ Travel alone ☐ High altitude ☐ Rural ☐ Cities ☐

Staying in hotels ☐ Staying with families ☐ Youth Hostel ☐ Safari ☐ Outdoor Activities ☐ Dorm ☐

Previous travel: Country _____ Year _____ Country _____ Year _____

Immunization History	**Yes**	**No**
Have you ever fainted from having your blood drawn or from an injection?	☐	☐
Have you ever had a fever or bad reaction/side effect from any vaccine?	☐	☐
Which vaccination? _____		
Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder or is on chemotherapy for cancer?	☐	☐
Have you received any injection of immune globulin or any blood product during the past 12 months?	☐	☐
Have you received any prednisone or steroids during the past 12 months?	☐	☐

Medications

1. List current medications (including oral contraceptives) and any over the counter medications you are currently taking:

_____

_____

_____

2. I am currently not taking any medications ☐

Allergies	**Yes**	**No**
Are you allergic to:		
• Any medications?	☐	☐
What type of reaction did you have? _____		
If yes, please list medications: _____		
• Bee stings or do you have a history of hives or urticaria?	☐	☐
• Eggs?	☐	☐
Have you had any adverse reactions to vaccines?	☐	☐

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General Medical	Yes	No	Don't Know
Have you had diseases of thymus gland or thymus surgery?	☐	☐	☐
Do you have a medical condition that warrants maintenance medications or physician follow-up?	☐	☐	☐
List here: _____			
_____			
Do you have a medical condition that is stable now, but that may recur while traveling?	☐	☐	☐
List here: _____			
_____			
Have you had a fever or felt sick in the past 48 hours?	☐	☐	☐
Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	☐	☐	☐
Have you or any member of your family ever had a problem with blood clots?	☐	☐	☐
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	☐	☐	☐
Please specify: _____			
Do you have heart disease, with or without symptoms? Specify: _____	☐	☐	☐
Do you have spleen disease or have had a splenectomy?	☐	☐	☐
Do you have a G6PD deficiency?	☐	☐	☐
Do you have kidney impairment?	☐	☐	☐
Have you ever had hepatitis or yellow jaundice?	☐	☐	☐
Do you have a bowel condition such as diarrhea or constipation?	☐	☐	☐
Do you have a history of depression, anxiety or other psychological concerns?	☐	☐	☐
Please specify: _____			
Do you have allergies or asthma?	☐	☐	☐
Do you have any eye conditions or glaucoma?	☐	☐	☐
Are you prone to motion sickness?	☐	☐	☐
Are you pregnant or might become pregnant on this trip?	☐	☐	☐

Immunizations

Please obtain documentation of immunizations /vaccinations from your doctor's office or other medical facility. Fax this COMPLETED form and immunization document(s) to 515-294-9225, or bring to TSHC.

It is your responsibility to contact TSHC at 515-294-5801 (option 1) 24-48 hours after faxing the information to schedule your appointment.

PLEASE DO NOT E-MAIL THIS FORM