IOWA STATE UNIVERSITY
Thielen Student Health Center

2847 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
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International Travel Questionnaire

Patient Information DATE:

Patient Name (Last, First, Middle, Maiden):	
Current Address (include City, State, Zip):	
University ID#	Date of Birth (MM/DD/YYYY):
Phone #:	Email Address:
Are you required to have a physical examination/statement of health before you travel? ☐ YES ☐ NO *(as directed by the Study Abroad Office or other coordinating office?)*	

Travel Dates:	Purpose of Travel:
Destination Country(ies):	
Check all that apply: ☐ Travel with group ☐ Travel Alone ☐ High Altitude ☐ Rural ☐ Cities ☐ Safari ☐ Staying in hotels ☐ Staying with families ☐ Youth Hostel ☐ Dorm ☐ Outdoor Activities	
Previous Travel: (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? If yes, 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?		

ALLERGIES	YES	NO
Are you allergic to any medications? If yes, please list: _____ Type of reaction: _____		
Are you allergic to bee stings or do you have a history of hives or urticaria?		
Are you allergic to eggs?		
Have you had any adverse reactions to vaccines?		

PATIENT NAME: _____ DOB: _____

MEDICATIONS

List current medications, including oral contraceptives, and any over-the-counter medications you are currently taking:

_____

_____

I am NOT taking any medications. ☐

GENERAL MEDICAL HISTORY	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? Please list: _____			
Do you have a medical condition that is stable now, but that may recur while traveling? Please list: _____			
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? Please 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 could you 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