IOWA STATE UNIVERSITY
Thielen Student Health Center

2847 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-294-9225

TRAVELER HISTORY FORM

Once this completed form and immunizations are received, a student health representative will contact you to schedule an appointment with our travel clinic. Please allow time for staff to review.

PATIENT INFORMATION	**DATE:**
Patient Name (Last, First, Middle, Maiden):	
Current Address (include City, State, Zip):	
University ID#	Date of Birth (MM/DD/YYYY):
Gender: ☐ Male ☐ Female ☐ Other:	☐ Student ☐ Other:_____
Phone #:	Email Address:

TRAVEL PLANS (LIST ADDITIONAL INFORMATION ON BACK OF FORM IF NEEDED):

Purpose of trip (check all that apply):

☐ Vacation ☐ Research ☐ ISU Study Abroad ☐ Visit Friends or Family ☐ Missionary/volunteer/humanitarian relief

☐ Work (urban, office-based or conference) ☐ Work (rural, outdoors or in local community

☐ Other: _____

Planned activities (list all):

Will you be:

Visiting areas that are:

Rural ☐ Yes ☐ No ☐ Not sure

Urban ☐ Yes ☐ No ☐ Not sure/**Primitive or remote** ☐ Yes ☐ No ☐ Not sure

Ascending to high altitudes (8,000 ft or higher) ? ☐ Yes ☐ No ☐ Not sure

Working with potential exposure to body fluids (ie. medical or dental work)? ☐ Yes ☐ No ☐ Not sure

Working with exposure to animals? ☐ Yes ☐ No ☐ Not sure

Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

Accommodations (check all that apply):

☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise Ship ☐ Private home (with locals)

☐ Private home (with relatives) ☐ Private home (expatriate or high-end) ☐ Primitive camping ☐ Up-scale camp/lodge

☐ Dormitory/hostel ☐ Other: _____

Previous international travel (year/destination)/Previous use of anti-malaria medication (year/destination):

PATIENT NAME: _____ DOB: _____

COUNTRIES AND CITIES IN ORDER OF VISIT	ARRIVAL DATE	DEPARTURE DATE

HEALTH HISTORY (Check all that apply)

ALLERGIES
- ☐ Antibiotics (ie. penicillin, sulfa): _____
- ☐ Other medications: _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other: _____
- ☐ Side effects/reactions from previous medications (ie. nausea, dizziness, stomach upset): _____

CANCERS/BLOOD DISORDER
- ☐ Coagulation disorder/blood clots
- ☐ History of cancer or blood disorder
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other: _____

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other: _____

GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other: _____

HEENT
- ☐ Glaucoma
- ☐ Other: _____

IMMUNE SYSTEM
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medications or treatments within last 3 months (ie. radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - Most recent CD4: _____
  - Most recent viral load: _____
- ☐ Organ, bone marrow, stem cell transplant _____
- ☐ Other: _____

KIDNEYS
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other: _____

LUNGS
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ RA
- ☐ Psoriatic Arthritis
- ☐ Other: _____

NEUROLOGIC/PSYCHIATRIC
- ☐ Seizure or epilepsy
- ☐ Anxiety/depression
- ☐ History of Guillain-Barré
- ☐ Other: _____

SKIN
- ☐ Psoriasis
- ☐ Other: _____

OB/GYN
- ☐ Pregnant: _____weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other: _____

VACCINATION HISTORY (Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

COVID-19	☐ Yes, When _____	☐ No	☐ Not sure
Hepatitis A	☐ Yes, When _____	☐ No	☐ Not sure
Hepatitis B	☐ Yes, When _____	☐ No	☐ Not sure
Meningococcal	☐ Yes, When _____	☐ No	☐ Not sure
Measles/Mumps/Rubella	☐ Yes, When _____	☐ No	☐ Not sure
Polio	☐ Yes, When _____	☐ No	☐ Not sure
Tetanus	☐ Yes, When _____	☐ No	☐ Not sure
Typhoid	☐ Yes, When _____	☐ No	☐ Not sure
Yellow Fever	☐ Yes, When _____	☐ No	☐ Not sure
Japanese Encephalitis	☐ Yes, When _____	☐ No	☐ Not sure
Influenza	☐ Yes, When _____	☐ No	☐ Not sure
Other: _____			

Have you ever had an adverse reaction to an immunization? ☐ No ☐ Yes Explain:

PATIENT NAME: _____ DOB: _____

CURRENT MEDICATIONS	
PRESCRIPTION MEDICATIONS: *List all current prescription medications*	
MEDICATION	**REASON FOR USE/MEDICAL CONDITION**
NON-PRESCRIPTION PRODUCTS: *List current over-the counter, herbal, homeopathic products, vitamins, supplements, etc.*	
PRODUCT	**REASON FOR USE/MEDICAL CONDITION**
QUESTIONS/CONCERNS	

Email ***form and immunization record(s) to shctravel@iastate.edu, or bring into Thielen Student Health Center.***

PLEASE NOTE:

If a Yellow Fever vaccine is recommended, you may need to seek care at another local travel clinic.