Travel Clinic Patient Questionnaire
Student Health Services

The Travel Clinic provides international travelers with information about the countries they are planning to visit, evaluates healthcare needs and risks, and provides immunizations and consultations. Students anticipating travel should make an appointment a minimum of eight (8) weeks before traveling to allow time for any counseling and administration of immunizations. Call 803-777-9511 (or 803-777-1448) for an appointment.

Please fill out this form and call to make an appointment. There is a charge for travel consultations and any charges for immunizations and medications. Several appointments may be needed. Bring your immunization records with you to your travel consultation.

Contact our Immunization coordinator by phone 803-777-9511 (or 803-777-1448)

Name: (please print)__________________________________________ Date of Birth: _____/_____/_______
Address: ____________________________________________________ Gender: Male Female
Home phone: _________________________ Work phone: ___________________________
Email address: ______________________________________________ Social Sec. #: _______________________

INFORMATION REGARDING TRAVEL PLANS
Date of departure: _____/_____/_______

List the countries in order to which you will be traveling:
____________________________________________
____________________________________________
____________________________________________
____________________________________________
Length of stay:
____________________________________________
____________________________________________
____________________________________________
____________________________________________

Is your travel to: (circle one) urban areas / rural areas / urban and rural areas

What is the reason for travel? (pleasure, business, medical work, study abroad, etc)
__________________________________________________________________________________________________
How did you hear about our services? ___________________________________________________________________

Have you ever had the following diseases or received vaccines for:

<table>
<thead>
<tr>
<th>Disease/Immunization</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox</td>
<td></td>
<td></td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella vaccine</td>
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</tbody>
</table>

Are you currently being treated for cancer?

Are you breast feeding?

Please list any existing medical conditions (heart disease, diabetes, etc):
_________________________________________________________________________

Please list all medications you are taking (prescriptions and over-the-counter):
_________________________________________________________________________

QUESTIONS FOR WOMEN

Are you pregnant, suspect you may be pregnant, or trying to become pregnant?
YES NO

If pregnant, how many weeks?

Are you breast feeding?

If you are breastfeeding or pregnant, you must see your OB physician. We cannot administer immunizations to these individuals without a written order from the OB physician.
**Immunizations**
- Have you ever fainted from having your blood drawn or an injection? [Yes | No]
- Have you ever had a fever reaction to vaccination? [Yes | No]
- Have you ever had any bad reaction or side effect from any vaccination? [Yes | No]
- Have you ever had the hepatitis A or B vaccine? [Yes | No]
- Do you live (or work closely) with anyone who has AIDS, any AIDS-like condition, any other immune disorder, or who is on chemotherapy for cancer? [Yes | No]
- Have you had a medical condition that warrants maintenance or physician follow-up? [Yes | No]
- Have you had a fever in the past 48 hours? [Yes | No]
- Are you pregnant or might you become pregnant on this trip? [Yes | No]
- Do you have AIDS, any AIDS-like condition, any other immune disorder, leukemia, or cancer? [Yes | No]
- Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma? [Yes | No]
- Do you have severe thrombocytopenia (low platelet count) or coagulation disorder? [Yes | No]
- Do you have any stomach conditions? [Yes | No]
- Do you have a G6PD deficiency? [Yes | No]
- Do you have severe renal impairment? [Yes | No]
- Do you have bowel conditions such as diarrhea or constipation? [Yes | No]
- Have you ever had hepatitis or yellow jaundice? [Yes | No]
- Do you have a history of psychiatric problems? [Yes | No]
- Do you have problems with strange dreams and/or nightmares? [Yes | No]
- Do you have insomnia? [Yes | No]
- Do you have problems with vaginitis? [Yes | No]
- Do you have psoriasis? [Yes | No]
- Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis? (i.e. itchy, red, scaly rash lasting >2 weeks that often comes and goes) [Yes | No]
- Do you have cardiac disease, with or without symptoms? [Yes | No]
- Do you have any eye conditions? [Yes | No]
- Are you prone to motion sickness? [Yes | No]
- Have you ever had a convulsion, seizure or epilepsy, neurologic condition or brain infection? [Yes | No]

**Medications - Are you taking or will you be taking:**
- quinine, quindine or medications for cardiac conduction defect? [Yes | No]
- chloroquine, mefloquine or proguanil to prevent malaria? [Yes | No]
- steroids, prednisone, cortisone, or anti-cancer drugs? [Yes | No]
- antibiotics or sulfonamides? [Yes | No]
- Pepto-Bismol to prevent traveller’s diarrhea? [Yes | No]
- antacids? [Yes | No]
- oral contraceptives? [Yes | No]
- aspirin therapy? [Yes | No]
- medications for emotional conditions? [Yes | No]
- medications for convulsions? [Yes | No]

**Allergies - Are you allergic to:**
- any medications? [Yes | No]
- Amphotericin B? [Yes | No]
- penicillin or sulfa? [Yes | No]
- mercury or thimerosal? Only vaccines containing > trace of thimerosal are listed. [Yes | No]
- Aminoglycoside antibiotics (streptomycin, neomycin, kanamycin, gentamicin)? [Yes | No]
- polymyxin? [Yes | No]
- sulfites? [Yes | No]
- aluminum or aluminum hydroxide? [Yes | No]
- benzethonium chloride? [Yes | No]
- 2-phenoxyethanol? [Yes | No]
- bee or other insect stings or history of hives or urticaria? [Yes | No]
- yeast? [Yes | No]
- eggs? [Yes | No]
- glycerin or chlorotetracycline? [Yes | No]
- latex? [Yes | No]
- Are you hypersensitive to gelatin? [Yes | No]
- Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formaldehyde? [Yes | No]

**CONTRAINdICATION**
- DTap,Td,Tdap [Yes | No]
- Varicella, smallpox, influenza (FluMist) [Yes | No]
- Varicella, smallpox [Yes | No]
- Varicella, measles-containing vaccine, smallpox [Yes | No]
- Yellow fever [Yes | No]
- any intramuscular injection [Yes | No]
- Oral typhoid, Mefloquine, Doxycycline [Yes | No]
- Chloroquine, Primquine [Yes | No]
- Malarone [Yes | No]
- Melloquine [Yes | No]
- any antibiotic [Yes | No]
- Chloroquine or related compounds [Yes | No]
- small pox [Yes | No]
- small pox, Influenza (FluMist) [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Mefloquine [Yes | No]
- Oral cholera (Mutacol), Oral typhoid [Yes | No]
- MMR or components, oral typhoid, varicella, yellow fever, influenza (Flu Mist) [Yes | No]
- Oral typhoid, oral cholera (Mutacol) [Yes | No]
- Doxycycline, tetracycline [Yes | No]
- Doxycycline, tetracycline [Yes | No]
- Doxycycline, tetracycline [Yes | No]
- Varicella, Influenza(FluMist) [Yes | No]
- Melloquine [Yes | No]
- Melloquine [Yes | No]
- Rabies (PCEC) [Yes | No]
- Diamox, Fansidar, Penicillin, Sulfas [Yes | No]
- DT(multi-dose), trimethoprim (multi-dose, booster), Influenza(Fluzone multi-dose, Fluvirin), Japanese encephalitis, Meningococcal (Menomonee multidose) [Yes | No]
- Hepatitis A/B (Twirix) Influenza, IPV, MMR or components, Rabies (HDCV and PCEC), Varicella, Smallpox, PEDIARIX [Yes | No]
- Influenza(Fluzone IPV, Smallpox, PEDIARIX [Yes | No]
- Doxycycline [Yes | No]
- Hep A, Hep B, Hep A/B (Twirix), COMVAX, DTap, Td, Rabies (RVA), Anthrax, PCV, Tdap [Yes | No]
- Anthrax [Yes | No]
- Hep A/Havrix, Hep A/B (Twirix), IPV, Dtap [Infantrix, PEDIARIX], Tdap, ADACEL [Yes | No]
- Japanese encephalitis [Yes | No]
- Hep B, Hep A/B (Twirix), PEDIARIX, oral cholera (Mutacol) [Yes | No]
- Yellow fever, MMR or components, Smallpox [Yes | No]
- Varicella, Japanese encephalitis, MMR or components, DTap, Yellow fever, MMR or components, Smallpox [Yes | No]
- Varicella, Japanese encephalitis, MMR or components, DTap, Yellow fever, MMR or components, Smallpox [Yes | No]

The statements above are true to the best of my knowledge. Signed ________________________________ Date _________________

Note: Any problem listed below may be a contraindication or merely a precaution that warrants further discussion between the healthcare provider and patient. This list is not all inclusive, but is representative of common issues that arise in a pre-travel consultation.