Appalachian State University
Student Health Service
Travel Services Questionnaire

For Office Use Only

Date Submitted: _____ Scanned By: _____

Appt. Date. Time: _____

☐Paid ☐Individual ☐Group

You must complete this form and return it BEFORE
you will be scheduled an appointment with the Travel Nurse

Name: _____ Banner ID #: _____

Address: _____

Telephone: (Cell) _____ (Other) _____

ASU E-mail: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Travel Itinerary

A. Travel Specifics: Date of Departure from USA: _____ Date of Return to USA: _____

Traveling: ☐ Alone ☐ Group ☐ Both ☐ Agency Sponsoring Trip: _____

Agency Contact Person: _____ Phone: _____

	Country	Region/City	Length of Stay
1.			
2.			
3.			
Additional Countries, Side Trips or Regions Being Visited:			

B. Purpose of the trip:

☐ Pleasure/Tourist ☐ Visiting Friends/Relatives ☐ Term/Year Abroad ☐ Humanitarian/Mission Trip

☐ Research/Study ☐ Business ☐ Short-Term Faculty Lead ☐ Peace Corp

C. Activities planned: _____

D. Will you be working in the medical or dental field with exposure to blood or body fluids or exposure to animals?

☐ Yes ☐ No If so, where will you work and what work will you be doing: _____

_____

E. Will you be in mosquito infested areas? ☐ Yes ☐ No

F. What type of accommodations will you be staying in?

☐ Staying on the international hotel circuit ☐ Visiting only urban areas ☐ Staying and/or eating with local families

☐ Visiting or sleeping in rural areas ☐ Camping/ Wilderness ☐ Dorm Style

☐ Hostel ☐ Other _____

G. Are you anticipating any of the following during your trip? ☐ None

☐ High Altitude ☐ Unsanitary Conditions ☐ Rafting or other water sports ☐ Safari

☐ Animal Contact ☐ Refugee Contact ☐ Providing Medical Care ☐ Extreme Sports

~Continued on Other side~

H. General Medical History:

1. Please list ALL medications you take on a regular basis, including ALL over-the-counter medications & birth control

2. Please list all on-going medical problems (major or minor)

3. Do you take any medications that suppress the immune system? ☐ Yes ☐ No

   If so, please list: _____

4. Do you have or have you ever had an allergic reaction to any of the following? (if answer is yes, check boxes below) ☐ No

   ☐ Eggs ☐ Yeast ☐ Any Foods: (list) _____

   ☐ Bee Stings/ Insect Bites ☐ Thimerasol or Mercury ☐ Neomycin ☐ Azithromycin

   ☐ Tetracycline/ Doxycycline ☐ Quinines/ anti-malarias ☐ Penicillin ☐ Sulfa

   ☐ Any additional medication allergy or sensitivity: _____

   ☐ Any other food or environmental allergy: _____

5. Do you have any of the following conditions? (if answer is yes, check boxes below) ☐ No

   ☐ Psoriasis or other skin condition ☐ Psychiatric disorder or taking any psychiatric medication

   ☐ History of epilepsy or seizure disorder ☐ Heart problems or high blood pressure

   ☐ Stomach problems or taking antacids frequently ☐ HIV/AIDS or immune deficiency

   ☐ Abnormalities of blood clotting ☐ History of Hepatitis or jaundice

   ☐ Blood disorder known as G6PD deficiency ☐ History of cancer

   ☐ Kidney Problems ☐ Eye Problems ☐ Insomnia

6. Have you received immune globulin or any blood product during the past 12 months? ☐ Yes ☐ No

   If yes, what did you receive: _____

7. Have you ever had a fever or a bad reaction from a vaccination? ☐ Yes ☐ No

   If yes, what did you receive: _____

8. Will you potentially have sexual contact with someone other than you normally would at home? ☐ Yes ☐ No

9. Females: Are you ☐ Pregnant? ☐ Plan to get pregnant in the near future? ☐ Breastfeeding ☐ Not Applicable

10. Have you or an immediate family member been told you/they have Long QT Syndrome or Torsades de Pointes? ☐ Yes ☐ No

11. Please list any specific concerns or needs related to your health for this trip:

12. Did you have Chicken Pox (Varicella Disease) as a child? ☐ Yes ☐ No ☐ Unsure

13. Have you had a Flu Shot/Flu Mist THIS flu season? ☐ Yes ☐ No

I certify, the information I have provided is correct and complete to the best of my knowledge.

Signature: _____ **Date:** _____