

**UofL Campus Health Services Travel Medicine
Foreign Travel Questionnaire**

Belknap: (502)852-6479 HSC: (502)852-6446

You must complete and return this form to Campus Health **BEFORE** your scheduled visit.

Name: _____	Date of Birth: _____
Address: _____	Student/Employee ID# _____
_____	Phone: _____

TRIP/ITINERARY INFORMATION:

I am traveling on my own

with a non-UofL program: _____ (Please specify)

with a UofL sponsored group: Trip Leader/Planner: _____

Trip Name/Destination: _____

Trip Details/Itinerary:

Date of departure: ___/___/___ Date of Return: ___/___/___

List all cities, regions, and countries to which you will travel in the order of travel:
(We must know all cities and side trips in order to determine immunization and medication needs. Include all non-US cities in which your plane will stop during transit.)

CITY/REGION, COUNTRY	LENGTH OF STAY

CHECK ALL THAT APPLY IN EACH SECTION:

AREAS VISITING:	STAYING IN:	ACTIVITIES:	
<input type="checkbox"/> Urban	<input type="checkbox"/> Dorm/residence hall	<input type="checkbox"/> Studying	<input type="checkbox"/> Medical/dental work
<input type="checkbox"/> Rural	<input type="checkbox"/> Hotel/hostel	<input type="checkbox"/> Relief work	<input type="checkbox"/> Vacation
<input type="checkbox"/> Remote	<input type="checkbox"/> National home/friend's home	<input type="checkbox"/> Visiting family/friend	<input type="checkbox"/> High altitude (>5000 feet)
<input type="checkbox"/> Unsure	<input type="checkbox"/> Camping	<input type="checkbox"/> Hiking/climbing	<input type="checkbox"/> Rafting
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Scuba/snorkeling	<input type="checkbox"/> Caving

Do you have any medical conditions or concerns that you'd like to discuss in relation to travel?

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Patient Name: _____ Date of Birth: _____

ALLERGIES: No known allergies

Food (Specify): _____ **If yes→** Do you carry an Epi-pen? Yes No

Medication (specify) _____ **Reaction:** _____

Medication (specify) _____ **Reaction:** _____

Bee stings: If yes→ Do you carry an Epi-pen? Yes No

MEDICAL CONDITIONS:

<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Respiratory/lung problem
<input type="checkbox"/> Blood/clotting disorder	<input type="checkbox"/> Immune deficiency	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Kidney/bladder problem	<input type="checkbox"/> Steroid therapy (current)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver problem	<input type="checkbox"/> Stomach/intestinal problem
<input type="checkbox"/> Ear problem	<input type="checkbox"/> Mental health history	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Eye/vision problem	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Other
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Pregnant/nursing	<input type="checkbox"/> Other

CURRENT MEDICATIONS (Include prescription, over the counter, and supplements):

HOSPITALIZATIONS/SURGERIES

DATE

HOSPITALIZATIONS/SURGERIES	DATE

FEMALES ONLY: Date of last menstrual period: __/__/__ I am or could be pregnant.

Current method of birth control: _____

I attest that the above information is accurate and complete to the best of my knowledge. I understand that, because of my participation in this trip and travel medicine appointment, I will be advised by a healthcare provider affiliated with the University of Louisville's Campus Health Services as to the required and/ or recommended immunizations, medications, and travel precautions for my trip. It is my responsibility to comply with their recommendations. I understand that refusing recommended medications or immunizations could result in serious medical illness. I understand that this consultation does not represent a medical clearance for travel. I will not hold the University of Louisville or Campus Health Services responsible should I contract illnesses or suffer injury associated with this trip.

Student Signature: _____ **Date:** __/__/__