ARIZONA STATE UNIVERSITY

Campus Health International Travel Questionnaire

Name:_____ **ID#:**_____

Itinerary: _____

Date: _____ **Date(s) of Travel:** _____

Please complete the entire questionnaire and submit to the clinic for your appointment	**YES**	**NO**
Do you need a medical/health clearance form completed for studying/working abroad?		

Do you have a medical condition that warrants maintenance medications or regular physician care (for example: high blood pressure, asthma, diabetes, etc)?		
Do you have a medical condition that is stable now, but that may recur while traveling?		
Have you had a fever in the past 48 hours and/or are you feeling sick today?		
Are you pregnant or might you become pregnant on this trip?		
Do you have HIV/AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?		
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?		
Do you have a low platelet count, a bleeding problem, or blood clotting disorder?		
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or a brain infection?		
Do you have G6PD deficiency?		
Do you have any chronic kidney problems?		
Do you have a chronic gastrointestinal condition such as ulcers, chronic diarrhea or colitis?		
Have you ever had hepatitis or yellow jaundice?		
Do you have any active mental health issues that require counseling or medications?		
Do you have recurrent nightmares or recurrent anxiety?		
Do you have recurrent or active asthma or a history of anaphylaxis (life threatening allergic reaction)?		

Do you have any heart disease, with or without symptoms?		
Do you have any chronic eye conditions **aside** from corrective lenses (glasses, contacts)?		
Have you received an organ transplant?		
Are you or will you be taking steroids/prednisone, immune suppressants or anti-cancer drugs?		

***<u>For Campus Health Scheduling Staff</u>*: if any "YES" to the above, please schedule a routine <u>physician</u> travel visit; if all "NO" to the above, may schedule patient for nurse travel clinic only.**

For Students- please continue to complete the remainder of the questionnaire	**YES**	**NO**
Have you ever fainted from having your blood drawn or from an injection?		
Have you ever had a fever or adverse reaction to a vaccination?		
Do you live (or work closely) with anyone who has AIDS, any other immune disorder, on immune suppressive therapy or on chemotherapy for cancer?		
Does any person who lives with you or any person you take care of take cortisone, prednisone, other steroids, or receive radiation treatments?		

Please list all Medications (prescription and/or over the counter, including birth control pills):

Please fax completed questionnaire to (480) 965-6531 or bring in to Campus Health Services appointments desk <u>prior</u> to scheduling an appointment at (480)965-3349.

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Name:_____ **ID#:**_____

Please note below any diseases/vaccinations you have had, with dates, if known.

Disease name	**Had disease (dates if known)**	**Had vaccines (dates if known)**
Measles (rubeola)		
Mumps		
German measles (rubella)		
Chicken Pox (varicella)		
Hepatitis A Hepatitis B		
Rabies, Typhoid, Japanese Encephalitis (circle any of the above if have received)	N/A	
Tetanus/diphtheria: Have you received at least 3 doses of tetanus/diphtheria (Td) vaccine in the past (this includes DPT doses as a child)?	N/A	1) 2) 3) Most recent (mo/yr): /
Polio: Have you received at least 3 doses of polio vaccine, including childhood doses?		1) 2) 3) Most recent (mo/yr): /

Circle any of the following that you are allergic to:

Eggs	Yeast	Gelatin	Bee Stings	Latex	Aluminum
Penicillin	Sulfa/sulfur	Thimerosal	Phenol	Neomycin	Streptomycin
Formalin	Polymyxin B	Amphotericin B	2-phenoxyethanol	Chlorotetracyclin	

Describe the allergic reaction(s) to any of the above circled:

Please list any previous vaccine reactions:

Other allergies not listed:

Signature: _____ **Date:**_____
*(To be signed by Student Traveler **prior** to submission of questionnaire)*

Signature: _____ **Date:**_____
(To be signed by the Health Care Provider at the appointment)

Please fax completed questionnaire to (480) 965-6531 or bring in to Campus Health Services appointments desk prior to scheduling an appointment at (480)965-3349.