Texas State University
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Pre-Travel Health Consultation and History Form

Personal Information: Please complete this section Date:

Traveler's Name:

Date of Birth Male [ ] Female [ ]

Address:

Telephone: Home_____ Cell _____ Work _____
Email:

Occupation:

Country of Birth: Citizenship:

Trip Information:

Date of Departure from home: Return date/length of trip:
Have you traveled internationally in the past? Yes No Where? _____
Do you intend to travel frequently in the future? Yes No Maybe
Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:
1._____
2._____
3._____
4._____
5._____

Destination: Urban Rural Remote At High Altitude Beach

Purpose of trip: (circle all that apply)
Vacation Medical care Business Education Adoption Volunteer/Humanitarian
Visiting Friends and/or Relatives Long-stay traveler

Organized tour? Yes No Partly Explain:

Accommodations: Hotel Hostel Staying with locals/family/friends Rented House/Apt Camping Cruise Ship/Boat

Will you be travelling alone? Yes No If no, Explain

Planned Activities: (check all that apply)
___Air Travel ___Biking ___Hiking ___Swimming ___Rafting ___Boating ___Scuba
___Climbing/Trekking ___Contact with Animals ___Cave/spelunking ___Public Transport (bus, train, etc)
___Visiting schools, hospitals or orphanages ___Health Care Worker ___Occupational exposure
Other:

Have you obtained travel medical evacuation insurance? Yes No

Health History:

Health Care Provider: Telephone:

Address:

Do you have any chronic health problems you take medication for on a regular basis or see a health care provider? Yes No
If yes, please explain:

Are you currently under the care of a physician for any health problem: Yes No If yes, please explain:

When was your last dental visit?

Traveler's Name:_____ **Date of Birth:**_____

Health History, cont'd.:

Do you currently have or have a past history of:

Antidepressant or psychiatric medication use	Yes	No
Depression, anxiety, panic attacks	Yes	No
Seizures or convulsions	Yes	No
Cardiac conduction defect, have a pacemaker	Yes	No
Heart disease or surgery	Yes	No
Respiratory (lung) disease (i.e. asthma)	Yes	No
Muscle or bone problems	Yes	No
Intestinal problems including heartburn or reflux	Yes	No
Immune disorder (chemotherapy, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment)	Yes	No
Live/work closely with anyone with immune disorder/ undergoing chemotherapy	Yes	No
Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome)	Yes	No
History of altitude illness	Yes	No
Surgery or hospitalization in past 3-5 years	Yes	No
Have you had any transfusions or blood products in the past 5 years?	Yes	No
Have you ever had Hepatitis (liver infection)?	Yes	No
Has your spleen been removed?	Yes	No
Do you smoke?	Yes	No
Other medical problem	Yes	No

Please explain any "yes" answers:

Allergies:

Medication(s)	Yes	No	If yes, list:_____
Reaction to vaccine	Yes	No	If yes, list:_____
Egg or other food allergies	Yes	No	If yes, list:_____
Environmental (pollens, dust, hay fever, etc.)	Yes	No	If yes, list:_____
Animals	Yes	No	If yes, list:_____
Bee stings	Yes	No	

Have you ever experienced anaphylaxis (severe allergic reaction)? Yes No

Medications:

Please list **all** prescribed and over-the-counter medications and supplements you use:

Medication or supplement:	Reason for use:
1	
2	
3	
4	
5	

Women:

When was your last menstrual period?_____ Was it normal?	Yes	No
Are you currently or are you trying to become pregnant?	Yes	No
Any risk of an unplanned pregnancy?	Yes	No
Are you breastfeeding?	Yes	No

What form of contraception do you use? _____

Attach immunization records. It may decrease the number of immunizations you need.

Do you have any additional questions about your travel?

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature _____ Relationship if minor _____ Date _____

Reviewed by: _____ RN/ NP/ PA/ MD Date:_____