UNIVERSITY HEALTH SERVICES
Tang Center

CURRENT HEALTH

Name of personal health care provider		*Phone number*	
Address		*City*	*State/Zip Code*

Do you have any allergies?
❑ *Yes* ❑ *No* *If yes, please list and describe type of reaction*

Medications		Bee or wasp sting	
Environmental		Food (especially gelatin, eggs)	

❑ male ❑ female — *If female, are you currently pregnant?* ❑ yes ❑ no

MEDICAL HISTORY

Please check all applicable conditions below and explain in area provided, if necessary.
Indicate date of your last visit to a clinician for each condition.

☐ skin disease, eczema	*date last visit*	☐ heart problem	*date last visit*
☐ hay fever	*date last visit*	☐ jaundice/liver disease	*date last visit*
☐ back problem	*date last visit*	☐ lung disease	*date last visit*
☐ emotional/mental problems	*date last visit*	☐ cancer	*date last visit*
☐ seizure disorder	*date last visit*	☐ diabetes	*date last visit*
☐ digestive tract problem	*date last visit*	☐ blood disorder	*date last visit*
☐ headaches (frequent/severe)	*date last visit*	☐ urinary tract problem	*date last visit*
☐ high blood pressure	*date last visit*	☐ recent surgery	*type/date*
Please explain all conditions checked above		☐ recent hospitalization	*reason/date*
		☐ immune deficiency disorder	

MEDICATIONS

Please list all medications you take regularly. Include vitamins, non-prescription medications, oral contraceptives.

prescription medication	*non-prescription medication*	*oral contraceptive*
		other (specify)

PREVIOUS IMMUNIZATIONS

Please list dates for those immunizations you have received. BRING ALL RECORDS

Tetanus/diphtheria	*date(s)*	Typhoid	*date(s)*
Yellow Fever	*date(s)*	Hepatitis A	*date(s)*
German Measles (Rubella)	*date(s)*	Hepatitis B	*date(s)*
Pneumovax	*date(s)*	Measles	*date(s)*
Varivax/Chicken Pox	*date(s)*	Mumps	*date(s)*
Meningococcal	*date(s)*	Polio – OPV/IPV	*date(s)*
Tetanus/diphtheria/pertussis	*date(s)*	Rabies	*date(s)*
Influenza	*date(s)*	Japanese encephalitis	*date(s)*
Twinrix	*date(s)*	HPV vaccine	
Other (specify)	*date(s)*		

Have you ever received a tuberculosis (PPD) skin test? ❑ yes ❑ no
If yes, date(s) of test ❑ positive ❑ negative

Have you ever been treated for tuberculosis? ❑ yes ❑ no

NUMBER

NAME

DOB

INTERNATIONAL TRAVEL CARE HISTORY

UNIVERSITY HEALTH SERVICES
Tang Center

Local contact, in case of emergency or illness		
Name		*Relationship*
Address	*City/State/Zip Code*	*Phone number*

Travel Dates	
Departure date	*Return date*

ANTICIPATED TRAVEL CONDITIONS (*Check all that apply)*

❑ organized group travel	❑ first class hotel	❑ independent travel
❑ university dormitory / youth hostel	❑ camping	❑ private home

❑ working in contact with animals/insects &/or doing field work *(specify)*

❑ other *(specify)*

ITINERARY

Please list the countries you plan to visit in chronological order with an estimated duration of stay in each country.
Star [*] any countries in which you plan to camp or stay outside the major urban areas.

Country	*estimated duration*	*Country*	*estimated duration*	*Country*	*estimated duration*

Please describe any special problems you anticipate while traveling, or health concerns you wish to discuss with clinician.

Have you traveled previously to developing countries?
❑ Yes ❑ No If yes, where?

Have you taken antimalarial medicine in the past?
❑ Yes ❑ No If yes, which one?