Humboldt State University Student Health Center

Travel Consultation & Medical History Form

Patient must complete and turn in this form prior to making a travel consultation appointment at the Student Health Center

Page 1 – Must be filled out completely by the patient

_____ _____ _____

Last Name **First Name** **Middle Name** **Date of Birth** **Age**

What is your HSU enrollment status during the proposed period of travel: ☐Current HSU student; ☐Continuing HSU student (e.g. off for winter/summer break but enrolled @ HSU for coming semester; ☐Will not be enrolled at HSU due to graduating, transferring to another campus or other reason.

Proposed Departure Date: _____ **Proposed Return Date**: _____

Nature of trip (e.g. study abroad, vacation, hiking/camping, mountain climbing; working in or visiting health clinics/hospitals/prisons/shelters/orphanage/refugee camp or other other-please list)_____

_____

Country to be visited	Length of Stay	Urban settings	Rural settings	High Altitude settings	Tropical settings

What is Your General Health Status: ☐Very Good ☐Average ☐Other (describe)_____

_____

List Allergies (medications, foods, insect stings, skin contact) _____

List current or chronic medical conditions_____

List current acute (short term) **medications** (prescription & non-prescription). _____

_____

List Chronic (ongoing) **medications including contraceptives**:_____

_____

Are you under the care of a medical or mental health provider for any ongoing physical or mental health conditions or for prescription medication management? List diagnosis & provider name & contact information: _____

_____

Women: Are you pregnant or planning to attempt to get pregnant in the next three months: _____

_____

_

Page 2 – Top portion to be filled out by the patient, bottom portion to be filled out by the SHC clinician

How will your ongoing medical conditions & medications be managed during your travel? _____

_____

What plans have you made for obtaining medical care abroad, should the need arise? _____

_____

Do you have any activity restrictions or need accommodations or assistance related to your physical or mental health? ☐ Yes ☐ No Explain_____

_____

Check the Types & List Dates Given of All Previous Immunizations

Vaccine:	**Date Received:**	**Vaccine:**	**Date Received:**
☐Tetanus, Td, Tdap		☐Polio	
☐Hepatitis A		☐Japanese Encephalitis	
☐Hepatitis B		☐Rabies	
☐Measles, Mumps, Rubella (MMR)		☐Typhoid (oral)	
☐Most recent flu vaccine		☐Typhoid Injectable	
☐Meningococcal Vaccine (type)_____		☐Yellow Fever	
☐Varicella (Chicken Pox)		☐Other (name)	
☐HPV		☐Other (name)	

Have you ever had a bad reaction to a vaccine? _____ If so, please list the vaccine involved and describe the reaction_____

List the date and result of your most recent Tuberculosis Skin Test: _____

I certify that to the best of my knowledge, all the above information is true and correct.

_____ _____

Patient Signature **Date**

To be filled out by HSU SHC Clinician only

The Following Section Is For Student Health Center Clinician Use Only

Findings, Plan, Patient Education:

Immunizations Recommended

- ☐ Td/Tdap
- ☐ MMR
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Typhoid
- ☐ Influenza
- ☐ Meningococcal
- ☐ Polio
- ☐ Rabies
- ☐ Yellow Fever
- ☐ Japanese Encephalitis
- ☐ _____
- ☐ _____

Immunizations Given or Prescribed at HSU SHC – dose and date _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Page 3 to be filled out by HSU SHC clinician only

☐ **TB screening questionnaire administered and reviewed.**

_____ Pre-travel TB testing is not indicated

_____ Pre-travel TB testing recommended.

□ PPD performed on _____ Result: _____

□ T-spot performed on_____ Result: _____

Malaria Prophylaxis Recommendation

	Drug	**Adult Dose**
☐	None Indicated by patient's proposed itinerary.	
☐	Chloroquine phosphate (Aralen)	500 mg: 1 tab ***weekly*** from 1-2 weeks before exposure until ***4 weeks*** after exposure
☐	Doxycycline	100 mg: 1 cap ***daily*** from 1-2 days before exposure until ***4 weeks*** after exposure.
☐	Atovaquone/proguanil (Malarone)	250/100mg: 1 tab ***daily*** from 1-2 days before Exposure until ***7 days*** after exposure.

Prescriptions provided: (List date name, dose, quantity, instructions**):**

_____

_____

_____

_____

Medications recommended (OTC or future prescription): _____

_____

_____

Other Travel Related Topics Discussed:

☐ Indications, contraindications, side effects & alternatives for immunizations & medications

☐ Patient advised to have read and to again review CDC travel information for their destinations, CDC general travel health advice/disease prevention, and US State Department Travel information as described in attachedHSU SH Travel Instructions: www.cdc.gov/travel/ & http://travel.state.gov including but not limited to Traveler's diarrhea, parasite and insect/mosquito protection, travel survival, altitude, sun protection.

☐ Zika information if traveling to at risk areas – mosquito and sexual transmission

☐ Getting medical care abroad

☐ Indications for post travel medical care (fever, persistent diarrhea, post travel TB testing, etc.)

☐ Travel health questions from patient addressed.

☐ Other:_____

_____

_____

_ _____

_____

_____

HSU SHC Clinician Signature _____ Date _____