

University of St. Thomas

Travel Questionnaire / Health History

Date of Departure: _____

Date of Return: _____

Program sponsoring travel: _____

Staff/Faculty contact: _____

Purpose of travel: _____

Do you have travel medical insurance? Yes No If yes, does it include emergency medical evacuation? Yes No

Previous International travel Yes No Locations and dates: _____

Please indicate the countries you will be visiting in the order in which you will visit them, and the duration of time you will be in each country. (Include potential countries you may visit/side trips.)

Destination

Length of Stay

Please check all that apply to your travel plans:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Major resort hotels | <input type="checkbox"/> Cruise Ships | <input type="checkbox"/> Camping |
| <input type="checkbox"/> Staying with a family | <input type="checkbox"/> Small hotels | <input type="checkbox"/> Safari |
| <input type="checkbox"/> Rented foreign home | <input type="checkbox"/> Youth hostel | <input type="checkbox"/> Rural travel at any time |
| <input type="checkbox"/> Residence Hall | Other: _____ | |

Are you traveling: alone with a group both

Please check all the travel vaccines that you have received and list the dates you received them:

- | | |
|--|--|
| <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> Typhoid (oral or inject able) _____ |
| <input type="checkbox"/> Hepatitis B _____ | <input type="checkbox"/> Polio(oral or injectable) _____ |
| <input type="checkbox"/> Twinrix (combined hep A and B) _____ | <input type="checkbox"/> Yellow Fever _____ |
| <input type="checkbox"/> Tetanus-diphtheria _____ | <input type="checkbox"/> Japanese Encephalitis _____ |
| <input type="checkbox"/> Tetanus-diphtheria-pertussis (Adacel) _____ | <input type="checkbox"/> Rabies _____ |
| <input type="checkbox"/> Varicella _____ | <input type="checkbox"/> Cholera (Not available in U.S.) _____ |

History Of:

- | | |
|---|--|
| <input type="checkbox"/> Pneumococcal _____ | <input type="checkbox"/> Previous Malaria Prevention _____ |
| <input type="checkbox"/> Meningitis (menactra/menomune) _____ | <input type="checkbox"/> Mantoux(PPD/TB test) _____ |
| | <input type="checkbox"/> BCG vaccine _____ |