Lycoming College
Student Health Services
Travel Health Questionnaire

Date_____ Phone number_____

Name_____ Date of Birth_____ Country of birth_____

Sex assigned at birth □ M □ F gender ID □ M □ F □ other current passport □ Yes □ No

Does your current health insurance plan cover while overseas □ Yes □ No Do you have medical evacuation insurance □ yes □ No

Have you traveled previously □ No □ Yes: where_____

Will you be traveling alone □ Yes □ No: with whom:_____

Departure Date from US_____ Return Date to the US_____

List all countries, cities or villages to be visited	Arrival date	Departure date

Trip purpose:	Accommodations:	Trip activities
□ business □ vacation □ study/ school related □ missionary/ volunteer/ humanitarian □ cruise □ long stay	□ hotel (4/5 star) □ hotel (2/3 star) □ hostel □ private home □ camping □ safari □ staying with locals □ long stay housing/apartment	□ site- seeing/ tourist attractions □ biking □ hiking/climbing □ ascending to altitude >7000 ft in the mountains □ swimming □ scuba diving □ boating/ rafting □ health care worker □ contact with animals

Immunization	date	date	date	date
MMR				
Td/ Tdap				
Varicella/chickenpox				
polio				
Hepatitis A				
Hepatitis B				
Meningitis				
Typhoid (oral/injectable)				
Yellow Fever				
Rabies				
Japanese Encephalitis				
Pneumonia				
Influenza				
Other				

Patient name_____ Date of Birth_____

Medication allergies_____ Vaccine allergies_____

Environmental allergies (bee stings, hayfever, chrysanthemumus, etc.)_____

Food allergies_____ Other_____

Medical History		
Anxiety/ Depression □ Asthma □ Seizures □ Psoriasis □ Anemia □ Diabetes □ Gout □ Lung disease □	Heart disease or surgery □ Irregular heart beat □ High blood pressure □ Immunity problems □ Taking immune suppression drugs □ Cancer □ G6PD deficiency □ Prostate problems □	Eye problems □ Thyroid problems □ Liver disease □ Kidney disease □ Stomach/intestinal problems □ Blood clotting problems □ Other:

Current prescription medications_____

Current over the counter medications or herbal supplements_____

Women: Last menstrual period_____

Any possibility of pregnancy □Yes □No
Do you plan to become pregnant in near future □Yes □ No

List any travel questions or concerns you have:

_____

RN signature Date