University of Texas Health Services
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) _______________________ E-mail: _____________________________
(work) ___________________________ (cell) ______________________________
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 [ ]
Is this a fixed itinerary? Yes [ ] No [ ] Unsure [ ]
Purpose of trip: (check 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 [ ] Snorkeling [ ] Swimming [ ]
Rafting [ ] Boating [ ] Scuba [ ] Climbing/Trekking [ ]
Contacting 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 for which you take medication on a regular basis or see a health care provider? Yes [ ] No [ ]
If yes, please explain: ____
____
Are you currently being treated for any health problem: Yes [ ] No [ ]
If yes, please explain: ____
____

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 [ ]

Psoriasis (skin disease) ____ Yes [ ] No [ ]
Seizures or convulsions ____ Yes [ ] No [ ]
Cardiac conduction defect, have a pacemaker _____________________________ Yes [ ] No [ ]
Heart disease or surgery ____ Yes [ ] No [ ]
Respiratory (lung) disease ____ 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 _______________________ Yes [ ] No [ ]
Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome)_____ Yes [ ] No [ ]
History of altitude illness ____ Yes [ ] No [ ]
Surgery or hospitalization in the 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 drink alcohol regularly? ______________________________________ Yes [ ] No [ ]
Do you smoke? ____ Yes [ ] No [ ]
Have you ever had a TB test? ____ Yes [ ] No [ ]
History of tendonitis/Achille's heel rupture _______________________________ 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 Yes [ ] No [ ] if yes, list: ___________________________
(pollens, dust, hay fever, etc.)
Animals Yes [ ] No [ ] If yes, list: ___________________________
Bee stings Yes [ ] No [ ] If yes, list: ___________________________
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_______________________________________	_______________________________________

When was your last dental visit? _________________________

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? ____
Please tell us any additional information that you believe is important for us to know as you prepare for your current trip.
____
____

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

Traveler's signature ______________________________ Relationship of minor ____________ Date ________
Reviewed by: ________________________________ RN/ NP/ PA/ MD
Revised: 8/2010