*Scan in as Medical History/PreTravel Form*

# PRETRAVEL FORM

University of North Texas

Print this form and complete it, including your immunization history. When complete call our appointment desk (940 565 2333) to schedule your first appointment for a TRAVEL CONSULT to (Name of Country). Often a second visit is needed to complete the process.

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Name: UNT ID#: Age: Today's Date:
Country of Birth:
Any countries lived in >1 year:

Is this a UNT faculty led trip, individual travel, or other group travel? Circle one
List in order the places you will visit, dates, activity

| | Location | Specific City or Region (and rural R or urban U) | Dates of travel | Purpose |
|---|---|---|---|---|
| 1. | | | _____to_____ | |
| 2. | | | _____to_____ | |
| 3. | | | _____to_____ | |
| 4. | | | _____to_____ | |

Date of return to North America

What is the purpose of your travel? Circle all that apply: work study vacation mission/relief work medical work visiting relatives trekking/climbing adventure travel rural travel scuba working with animals cruise camping other_____

Will any of your travel be at altitude above 2000 meters?
If yes, how high, where and how many days?

Have you ever had an international travel related illness or injury?

Have you ever had a blood clot (DVT) or had to take blood thinners (coumadin or heparin)?

What is your biggest medical worry about this trip?

## MEDICAL HISTORY

List any specific medical conditions that you have:

Do you have irritable bowel syndrome, Crohn's disease or other intestinal problem?

Do you have a history of anxiety, depression, seizure disorder, ADHD or psychological problem?

Have you ever had asthma?

Medication allergies:

Routine medications---list name and dosage.

Do not forget to list above oral contraception, asthma and acne medications.

Women: What contraception method do you use?
Will you be pregnant or planning a pregnancy within two months of travel?

IMMUNIZATION HISTORY

Immunosuppression----This is the definition: Can be caused by HIV, cancer chemotherapy, organ or bone marrow transplant, genetic immune deficiency, diabetes, splenectomy, thymectomy, or immune suppression medication for arthritis, Crohn's disease or other conditions or taking daily steroid medication > 20 mg/day.

Are you immunosuppressed? No Yes
Do you live with or have close personal contact with someone who is immunosuppressed? No Yes

Have you ever had a reaction to any immunization? No If Yes, please explain:

Circle if allergic to these: eggs, yeast, mercury, neomycin, aluminum, latex, gelatin, lactose, bee stings?

Do you have sickle cell disease, sickle cell trait or G6PD deficiency?

Please complete the following:

| | Immunization Name | Dates of Administration | | |
|---|---|---|---|---|
| CHILDHOOD | Hepatitis A | #1 | #2 | |
| | Hepatitis B | #1 | #2 | #3 |
| | Twinrix (Hep A & Hep B) | #1 | #2 | #3 |
| | Polio (last dose) | Oral | Injected | |
| | Meningococcal | | | |
| | Td / Tetanus / TDAP | | | |
| | Measles / MMR | #1 | #2 | |

| | | | |
|---|---|---|---|
| TRAVEL | Influenza | | |
| | Japanese Encephalitis | | |
| | Rabies | | |
| | Typhoid | Oral | Injected |
| | Yellow Fever | | |

I certify that this information is accurate and correct:

Signature_____ Date_____

Reviewed by medical provider:

Signature_____ Date_____