

# University of Iowa Student Health International Travel Medical Questionnaire

Patient Name \_\_\_\_\_ ID number \_\_\_\_\_  
 Today's date \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ Contact phone \_\_\_\_\_

## ITINERARY

Destination(s) (City, Country)	Where will you stay?	Length of stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of travel? \_\_\_\_\_

## GENERAL MEDICAL INFORMATION

Yes	No	Don't Know
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Do you have a chronic medical condition that warrants maintenance medications or physician follow up? List here _____	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a medical condition that is stable now but that may recur while traveling? List here _____	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a spleen?			
Are you pregnant now or do you plan to become pregnant on this trip? Date of last menstrual period _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have AIDS, an AIDS-like condition, any immune disorder, leukemia, or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an autoimmune or rheumatic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had disease of the thymus or thymus surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you or any member of your family had a problem with blood clots or low blood platelet count?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a convulsion, seizure, epilepsy, neurologic condition or brain infection? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bladder or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bowel condition such as persistent diarrhea, constipation, or IBS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hepatitis or yellow jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of depression, anxiety or other psychological concerns? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or a member of your household ever been diagnosed with eczema, psoriasis or atopic dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep or experience strange dreams or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a stroke or heart disease of any sort?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any eye conditions or glaucoma (other than corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have asthma, allergies or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any medications or supplements? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have allergies to medications? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## IMMUNIZATIONS

**Please obtain documentation of immunizations/vaccinations from your doctor's office or other medical facility. Fax to 319-384-1703, Attention: TRAVEL, or bring to University of Iowa Student Health Service, the immunization document and this COMPLETED form. You must do this prior to scheduling your initial travel visit. If you fax information, allow 24 hours to process paperwork prior to scheduling your appointment.**