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**
Do you have a chronic medical condition that warrants maintenance medications or physician follow up? List here _____	☐	☐	
Do you have a medical condition that is stable now but that may recur while traveling? List here _____	☐	☐	
Do you have a spleen?			
Are you pregnant now or do you plan to become pregnant on this trip? Date of last menstrual period _____	☐	☐	☐
Do you have AIDS, an AIDS-like condition, any immune disorder, leukemia, or cancer?	☐	☐	☐
Do you have an autoimmune or rheumatic disease?	☐	☐	☐
Have you had disease of the thymus or thymus surgery?	☐	☐	
Have you or any member of your family had a problem with blood clots or low blood platelet count?	☐	☐	☐
Have you ever had a convulsion, seizure, epilepsy, neurologic condition or brain infection? Please specify _____	☐	☐	☐
Do you have G6PD deficiency?	☐	☐	☐
Do you have bladder or kidney disease?	☐	☐	☐
Do you have a bowel condition such as persistent diarrhea, constipation, or IBS?	☐	☐	☐
Have you ever had hepatitis or yellow jaundice?	☐	☐	☐
Do you have a history of depression, anxiety or other psychological concerns? Please specify _____	☐	☐	☐
Have you or a member of your household ever been diagnosed with eczema, psoriasis or atopic dermatitis?	☐	☐	☐
Do you have difficulty falling asleep or experience strange dreams or nightmares?	☐	☐	
Have you had a stroke or heart disease of any sort?	☐	☐	
Do you have any eye conditions or glaucoma (other than corrective lenses)	☐	☐	
Do you have motion sickness?	☐	☐	
Do you have asthma, allergies or wheezing?	☐	☐	
Do you take any medications or supplements? Please specify _____	☐	☐	
Do you have allergies to medications? Please specify _____	☐	☐	☐

IMMUNIZATIONS

Please obtain documentation of immunizations/vaccinations from your doctor's office or other medical facility. Fax to 319-335-7247, 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.