Penn State University Health Services – Travel Clinic Information

Travel Information Resources:
We are relying on you to read specific information about your destination and steps to take to remain healthy while you travel. Please review the websites below to become familiar with your destination, traveler's health topics, and additional information for your return home. The CDC's *Health Information for International Travel* ("Yellow Book") is a valuable resource on health information for the international traveler and can be viewed online https://wwwnc.cdc.gov/travel/page/yellowbook-home.

Centre for Disease Control	https://wwnc.cdc.gov/travel
Shoreland Travel Services	https://tripprep.com
Malaria	https://www.cdc.gov/parasites/malaria/index.html
Yellow Fever Vaccination	https://www.cdc.gov/yellowfever/index.html
Vaccine Information Statements	https://www.immunize.org/vaccines/vis/about-vis/
U.S. Department of State	www.travel.state.gov

U.S. Department of State-Bureau of Consular Affairs
https://travel.state.gov/content/travel/en/international-travel/before-you-go/step.html
Traveler's Insurance Plan:
http://studentaffairs.psu.edu/health/services/insurance/educationAbroad.shtml Other
Travel Medical Insurance Options:
https://travel.state.gov/content/passports/en/go/health/insurance- providers.html

Those scheduled to travel are encouraged to use the Global Safety - Penn State Travel Safety Network: https://gsn.psu.edu/login

Prior to Your Travel Appointment at UHS:

1. **Complete the Pre-Travel Health Consultation and History Form.**
2. **Obtain a copy of your immunization records from birth to present, including any blood/titer tests –**PSU Student may have submitted their immunization history to UHS at the time at admittance.
   Students can log into MyUHS and verify that UHS has their immunization records at: http://www.studentaffairs.psu.edu/health/myUHS/login.shtml
   For information on locating your immunization/vaccine records go to: https://www.cdc.gov/vaccines/adults/vaccination-records.html
3. **Fax or drop off your completed form and immunization records not already on file with UHS. Upon receipt, your travel appointment will be scheduled.**

Day of Your Appointment:

1. Please arrive 15 minutes prior to your scheduled appointment time and check in with a receptionist. Your appointment may take up to 60 minutes, and you will be required to wait 15 minutes after vaccinations are administered.
2. Please be sure that you have had something to eat and drink prior to your appointment.
3. For female patients: If your menstrual period is delayed, you may be asked to provide a urine sample for pregnancy screening prior to the administration or prescribing of any needed vaccines/medication.

**Promptly notify the UHS Travel Clinic of any changes or additions in your medical history or trip itinerary by fax at 814-86-2584, "Attention Travel Clinic", or by calling University Health Services at 814-865-4847, option 3.

The Travel Clinic utilizes TRAVAX, a computer software program which is updated weekly with information from the CDC, ACIP, AAP, and WHO, as well as ongoing global surveillance and published literature.

PennState Student Affairs | University Health Services

(Affix Patient Label Here)
Patient Name:

DOB:

PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Complete this form and FAX TO 814-865-6982 OR DROP OFF at UHS along with all immunization records.
Upon receipt of your completed form and immunization records, your appointment will be scheduled.

Today's Date: _____

Name: _____ DOB:_____ PSU ID#: _____

Legal Sex: ☐ Male ☐ Female ☐ Non-Binary Sex at Birth: _____ Pronouns: _____

Home Phone: _____ Work Phone: _____Mobile Phone: _____

Home Address: _____

City: _____ State: _____ Zip:_____ Email: _____

Country of Birth: _____ Citizenship: _____

Occupation: _____

Primary care physician's name: _____

Primary care physician's address: _____ Phone: _____

TRAVEL PLANS (list additional information on back of form if needed):

Date of Departure for Destination: _____ **Return Date/Length of Trip:** _____
Have you traveled internationally in the past? ☐ Yes ☐ No If yes, where?: _____
Do you intend to travel frequently in the future? ☐ Yes ☐ No

Countries and cities in order of visit (list all, including stopovers)	**Arrival Date**	**Departure Date**
1.		
2.		
3.		
4.		
5.		
6.		

Is your itinerary fixed? ☐ Yes ☐ No ☐ Not sure
Destination: ☐ Rural ☐ Urban ☐ Remote ☐ High Altitude (8,000ft/2500m or higher) ☐ Beach

Purpose of trip (check all that apply)
☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends or family ☐ Missionary/volunteer/humanitarian relief
☐ Work/Business ☐ Medical/Dental care ☐ Pilgrimage ☐ Long-stay traveler
☐ Other _____

Organized tour? ☐ Yes ☐ No ☐ Party Explain:
_____

Accommodations? ☐ Hotel ☐ Hostel ☐ Staying with locals/family/friends ☐ Dorm ☐ Camping
☐ Criuse ship/Boat ☐ Rented house/apartment ☐ Availability of bed nets

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DOB:

PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Will you be traveling alone? ☐ Yes ☐ No If no, explain:
_____

Do you plan to rent a car? ☐ Yes ☐ No

Planned activities:
☐ Air travel ☐ Biking ☐ Hiking ☐ Swimming ☐ Rafting ☐ Boating ☐ Scuba ☐ Climbing/Trekking
☐ Contact with animals ☐ Caves/Spelunking ☐ Public transport (bus, train, etc.) ☐ Snorkeling
☐ Visiting schools/hospitals or orphanages ☐ Medical/dental work ☐ Other: _____

Have you obtained travel medical evacuation insurance? ☐ Yes ☐ No

HEALTH HISTORY

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, explain: _____

Are you currently under the care of a physician for any health problem? ☐ Yes ☐ No
If yes, explain: _____
When was your last dental visit? _____
Do you smoke, vape, or use recreational drugs? ☐ Yes ☐ No
If yes, explain: _____
Do you drink alcohol regularly? ☐ Yes ☐ No
Have you ever taken undesirable risks or had an adverse reaction to the use of alcohol? ☐ Yes ☐ No
If yes, explain: _____

List any surgeries you have had in the past 5 years:

_____

Check all that apply:

Allergies
☐ Antibiotics (e.g., penicillin, sulfa)
☐ Other medications
☐ Egg
☐ Other Food Allergy: _____
☐ Latex
☐ Gelatin
☐ Yeast
☐ Bees/wasps
☐ Animals
☐ Seasonal/Environmental
☐ Vaccine
☐ Other _____
☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): _____
☐ Anaphylactic reaction (severe allergic reaction)

Cancers/blood disorder
☐ Coagulation disorder
☐ History of cancer or blood disorder
☐ Blood transfusion within the past 5 years
☐ Other _____

Skin
☐ Psoriasis
☐ Other

Endocrine
☐ Diabetes
☐ Thyroid disease
☐ Other _____

Cardiovascular
☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
☐ Implanted pacemaker or automatic defibrillator
☐ Heart attack
☐ High cholesterol
☐ High blood pressure
☐ Stroke
☐ Other _____

GI
☐ Crohn's disease or ulcerative colitis
☐ IBS
☐ GERD
☐ Chronic hepatitis
☐ Cirrhosis or liver failure
☐ Other _____

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PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Kidneys
☐ Dialysis
☐ Kidney insufficiency
☐ Other _____

Lungs
☐ Asthma
☐ Emphysema/COPD
☐ High Altitude Sickness
☐ Prior TB Testing
☐ Other _____

Immune system
☐ Steroids by mouth within last 3 months
☐ Allergy immunotherapy
- Date of last allergy injection: _____

☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
☐ Spleen removed
☐ G6PD Deficiency
☐ Myasthenia Gravis/DiGeorge Syndrome
☐ Thymus disease or thymectomy
☐ HIV/AIDS
- Most recent CD4: _____
- Most recent viral load: _____

☐ Organ, bone marrow, stem cell transplant _____
☐ Other _____

Musculoskeletal
☐ Rheumatoid arthritis
☐ Psoriatic arthritis
☐ Tendonitis/Achilles heel rupture
☐ Other _____

Neurologic/psychiatric
☐ Seizures or epilepsy
☐ Anxiety /depression
☐ History of Guillain-Barré
☐ Disordered Eating
☐ Other _____

Obstetrics/Gynecology
When was your last menstrual periods (LMP)? _____
Was your last LMP normal? ☐ Yes ☐ No
If no, explain: _____
Are you currently pregnant, trying to get pregnant, or planning a pregnancy in the near future? ☐ Yes ☐ No
Any risk of unplanned pregnancy? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
What form of contraception do you use? _____

Vaccination History:
Have you received a dose of the COVID-19 vaccine in the past 8 weeks?
☐ Yes ☐ No
Have you had a positive COVID-19 test or been diagnosed? with COVID-19 in the past 3 months?
☐ Yes ☐ No
Have you received a dose of Mpox vaccine in the last 4 weeks?
☐ Yes ☐ No

CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

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Patient Name:

DOB:

PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.	
Product	**Reason for use/medical condition**

Please tell us any additional information about your health history that you believe is important for us to know as you prepare for your trip, including any concerns or fears?

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

Patient/Traveler's Signature: _____ Date: _____

Office use only

Healthcare Provider's Signature: _____RN / NP / PA / MD

Date Reviewed: _____