ASU Health Services International Travel Questionnaire

Name:__________________________________ **ID#:**_______________
Phone #__________________

Itinerary (*include all excursions planned*):____

Today's Date: ____________________ **Date(s) of Travel**:____

******To Patients: please CAREFULLY read and complete this 2 page questionnaire and submit to the clinic for an appointment- inaccurate replies may lead to delays/rescheduling of your appointment***

	YES	NO
Aside from the ASU Study Abroad Office's required medical clearance, do you have a ***separate or additional*** medical clearance form that needs to be completed for studying/working/traveling? ***Examples**: CIEE, ISA, Semester at Sea, Fulbright, Peace Corps, Missionary, VISA applications*		
Do you have a medical condition that warrants medications or regular physician care (for example: high blood pressure, asthma, diabetes, depression, anxiety, ADHD etc)?		
Are you 55 years or older?		
Do you take prescription medications ***aside*** from birth control (regularly or as-needed)?		
Aside from diarrhea/anti-malaria medications and travel vaccinations, will be you requesting ***additional*** prescriptions (including medication refills) at this visit?		
Will the length of your travel be 3 months or greater in Asia, Africa or South America?		
Have you had a fever in the past 48 hours and/or are you feeling sick today?		
Do you have a chronic cough?		
Do you have a new rash or ongoing rash that has not been evaluated?		
Are you pregnant or might you become pregnant on this trip?		
Do you have HIV/AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?		
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?		
Do you have low platelet count, a bleeding problem, or blood clotting disorder? G6PD deficiency?		
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or a brain infection?		
Do you have any chronic kidney problems?		
Do you have a chronic gastrointestinal condition such as ulcers, chronic diarrhea or colitis?		
Have you ever had hepatitis or yellow jaundice?		
Do you have any mental health issues that require counseling and/or medications (anxiety, depression, bipolar, attention deficit/ADHD)?		
Do you have recurrent nightmares or recurrent anxiety?		
Do you have recurrent or active asthma, moderate-severe allergies, recurrent hives, or a history of anaphylaxis (life-threatening allergic reaction)?		
Do you have any heart conditions/disease, with or without symptoms?		
Do you have any chronic eye conditions **aside** from corrective lenses (glasses, contacts)?		
Have you received an organ transplant?		
Are you or will you be taking steroids/prednisone, immune suppressants or anti-cancer drugs?		

***For ASU Health Scheduling Staff*: if any "YES" to the above, please schedule the patient with a routine provider/clinician travel visit; if "NO" to all of the above, may schedule patient for nurse travel clinic only.**

To Patients- please continue to complete the remainder of the questionnaire

	YES	NO
Have you ever fainted from having your blood drawn or from an injection?		
Have you ever had a fever or adverse reaction to a vaccination?		
Do you live (or work closely) with anyone who has AIDS, any other immune disorder, on immune suppressive therapy or on chemotherapy for cancer?		
Does any person who lives with you or any person you take care of take cortisone, prednisone, other steroids, or receive radiation treatments?		

Please list all Medications (prescription, over-the-counter & supplements, birth control pills, etc):

Please fax completed questionnaire and attach your full immunization record to (480) 907-3040 or bring in to ASU Health Services reception desk prior to scheduling an appointment at (480)965-3349.

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So that we may provide the most accurate recommendations, please bring your vaccine records to review at your appointment- if you are unable to locate any records, please note any known vaccination/illness details below

Disease name	Had disease (dates if known)	Had vaccines (dates if known)
Mumps, Measles (rubeola), German measles (rubella)		MMR 1) 2)
Chicken Pox (varicella)		1) 2)
Meningococcus (meningitis, *not* HIB)		[ ] Menactra (MCV4) 1) 2) [ ] Menomune (MPSV4) [ ] Meningitis B (Trumenba or Bexsero- circle one)
Pneumococcus (pneumonia) Pneumovax or Prevnar 13		
Flu shot (influenza)		
Hepatitis A (two shot series *or* may be combined with B) Hepatitis B (three shot series)		1) 2) 1) 2) 3)
Rabies, Typhoid, Japanese Encephalitis, Yellow fever, Cholera (circle any of the above if have received)		
Tetanus/diphtheria: Have you received at least 3 doses of tetanus/diphtheria (Td) vaccine in the past (this includes DPT doses as a child)?	N/A	1) 4) 2) 3) Most recent (mo/yr): (/)
Polio: Have you received at least 3 doses of polio vaccine, including childhood doses?		1) 3) 5) 2) 4) 6) Most recent (mo/yr): (/)

Circle any of the following that you are allergic to:

Eggs Yeast Gelatin Bee Stings Latex Aluminum Penicillin Sulfa/sulfur Thimerosal Phenol
Neomycin Streptomycin Formalin Polymyxin B Amphotericin B 2-phenoxyethanol Chlorotetracyclin Protamine Sulfate

Describe the allergic reaction(s) to any of the above circled:

Please list any previous vaccine reactions:

Please list any other allergies not noted above (including medication and food allergies):

For ALL travelers, please sign form below once you have completed this form

******For ASU Study Abroad Travelers- by signing below, you authorize ASU Health Services to share with ASU Study Abroad Office (and those individuals responsible for coordinating your study abroad program) any pertinent but required medical information for your medical clearance (including minimally necessary details on any medications and medical conditions of concern).***
ASU Health Services does not make decisions about allowing students to participate in ASU Study Abroad Programs- we assess risk and make recommendations to both the student and ASU Study Abroad Office on how to mitigate these risks.
******If you wish to opt out of this and discuss this further at your visit, please initial here:*** _______

Signature: ____ **Date:**___________

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*(To be signed by Traveler **prior** to submission of questionnaire - if younger than age 18, the Parent or Legal Guardian must also sign)*

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