

Travel Consult Questionnaire

For a safe and healthy trip, please schedule your 30 minute travel consult appointment at least 4-6 weeks before departure. We provide a country specific travel packet which includes food/water/insect precautions/health and safety guide, travel vaccines, and prescriptions, if needed.

- **Please complete Travel Consult Questionnaire**
- **Bring all your immunization records to the appointment**
- **Vaccines available at the clinic:**
 - Hepatitis A and B
 - Influenza
 - Menactra (meningitis)
 - MMR
 - Td (tetanus)
 - Tdap (tetanus/diphtheria/acellular pertussis)
 - Typhoid (oral, lasts for 5 years)-prescription

* Call (408) 924-5678 for an appointment and fees or visit our [website https://sjsu.edu/wellness/](https://sjsu.edu/wellness/) *

Travel Consult Questionnaire

NAME (Last)	(First)
DATE	STUDENT/STAFF ID #

Medical History: Please circle "Yes" or "No" to the following questions:

	Yes	No
1. Have you ever had reactions to immunizations/travel vaccines?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergies to the following items? (Check all that apply) <input type="checkbox"/> Eggs <input type="checkbox"/> Neomycin <input type="checkbox"/> Antibiotics <input type="checkbox"/> Mercury (thimerosal) <input type="checkbox"/> Vaccines <input type="checkbox"/> Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>
3. Are there any other drugs to which you have had an allergic reaction? (Please list)	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you being treated for leukemia, lymphoma, cancer or any other malignant disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have or live with someone with a history of immune system deficiency?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a history of anemia or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any existing medical condition such as diabetes, heart disease or pulmonary disease?(If Yes, please list)	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any history of kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any history of psychiatric disorders?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a history of seizures?	<input type="checkbox"/>	<input type="checkbox"/>
12. List all the medications you are taking:	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you pregnant, suspect you may be pregnant or trying to become pregnant? Breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>

Reasons for travel: Education Pleasure Research Volunteer (i.e., medical)
Travel Information: Departure Date: _____ Return Date: _____

14. Please indicate; in order of travel the countries and cities you are traveling to:	Rural Travel or Camping?
Destination (City/ Country) Where will you stay? Length of Stay	Yes No
	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>
15. Please list any side or day trips planned:	
16. Will you be traveling above 8,000 feet?	<input type="checkbox"/> <input type="checkbox"/>
17. Do you plan to scuba dive?	<input type="checkbox"/> <input type="checkbox"/>