College of Charleston
Student Health Services Traveler History Form

Name:_____
SID#:_____

TRAVEL PLANS

Purpose of trip (e.g. study, business, vacation, etc.): _____
_____

Is this a College of Charleston affiliated trip (e.g. study abroad, international exchange or affiliate program)?
Yes No

If yes, please list the name of the professor or organizer_____

Are you traveling to (circle all that apply): Rural areas Urban area Primitive/remote areas

Countries and cities in order of visit (including airport layovers in countries with risk of Yellow Fever transmission). May attach additional sheets as necessary	**Arrival Date**	**Departure Date**	**Total days in location**

Accommodations (circle all that apply):

Major Resort Hotel Small Hotel Cruise ship Host Family Home (with friends or family) Camping

Dormitory/ hostel Other_____

During your travels, will you be:
Working in a medical capacity with potential exposure to body fluids? Yes No

Working with animals? Yes No

Traveling to high altitude locations (over 8,000 feet)? Yes No

Swimming? Pool Fresh water (lake, river or stream) Ocean

Do you suffer from motion sickness or are you concerned about motion sickness during your travels? Yes No

Previous international travel (include dates): _____
_____
_____

Health History

ALLERGIES: Are you allergic or hypersensitive to the following?	**YES**	**NO**
Any medications?	☐	☐
Previous reaction to vaccine or vaccine component?	☐	☐
Eggs, egg protein, ovalbumin, or chicken protein?	☐	☐
Yeast?	☐	☐
Bees/wasps/other insects?	☐	☐
Latex?	☐	☐
Gelatin?	☐	☐
Soy?	☐	☐
Seasonal or other environmental allergies?	☐	☐
Other?	☐	☐
Side effects or reactions from medications (e.g. upset stomach, dizziness, etc.)	☐	☐
GENERAL MEDICAL HISTORY **Do you have any history of the following:**	☐	☐
Any medical condition that requires maintenance medications or physician follow-up? Or do you have stable condition that could recur while traveling?	☐	☐
Cancer, blood disorder, low platelet count (thrombocytopenia), or other clotting disorder?	☐	☐
Cardiovascular condition including arrhythmia, heart attack, high cholesterol, high blood pressure, stroke, implanted pacemaker or other?	☐	☐
Immune disorder, thymus removal or disorder, HIV/AIDS, spleen removal; or are you taking an immune suppressive medication? Any steroid use within last 3 months?	☐	☐
Organ, bone marrow, or stem cell transplant?	☐	☐
Received any injection or immune globulin or any blood product in last year?	☐	☐
Diabetes, thyroid disease or other endocrine disorder?	☐	☐
Crohns disease, ulcerative colitis, IBS, GERD, hepatitis, cirrhosis or liver failure, or other gastrointestinal condition?	☐	☐
Dialysis, kidney insufficiency, or other kidney disease?	☐	☐
Asthma, emphysema/COPD, or other condition affecting the lungs?	☐	☐
Rheumatoid arthritis or psoriatic arthritis?	☐	☐
Seizures, convulsions, Guillain-Barré, other neurological condition?	☐	☐
Psoriasis or other skin condition?	☐	☐
Anxiety, depression, insomnia, strange dreams or nightmare, or other psychiatric problems?	☐	☐
Are you pregnant or breastfeeding or might you become pregnant during your trip?	☐	☐

Current Medications: **Please list all current prescription and over the counter medications including supplements (attach additional sheet as needed)**_____

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