UCSF Student Health & Counseling
Student Academic Affairs

Travelers' Name: _____ Date of Birth: _____ / _____ / _____

School Program: _____

Today's Date: _____ / _____ / _____

**ITINERARY:**

Departure Date: _____ / _____ / _____

*Destination:* _____ *Total Length of Stay:* _____

*Destination:* _____ *Total Length of Stay:* _____

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*Destination:* _____ *Total Length of Stay:* _____

**LODGING (***Check all that apply***):**

O Luxury/Businesss Hotel
O Homestay
O Camping
O Guest House
O Rental
O Cruise Ship
O Family/Friends
O Dorm
O Other (specify_____)

**ANTICIPATED ACTIVITIES (***Check all that apply***):**

O Scuba diving
O Caving
O Jungle travel
O Kayaking/Rafting
O Bicycling
O Motorcycle Riding
O Blood or Human Tissue Handling
O Adventurous/Exotic Cuisine
O Sex
- O with current partner
- O with new partner(s)

O High-altitude travel (>6,000-8,000 ft, > 1,829-2,438 m)
O Desert travel
O Camping/hiking
O Solo travel
O Driving
O Clinical Caregiving
O Animal Blood or Tissue Handling
O Swimming in fresh-water lakes/streams/rivers
O Mountain climbing
- O with ropes
- O without ropes

**ALLERGY HISTORY:**

Are you allergic or hypersensitive to any of the following *(check all that apply):*

O Eggs
O Yeast
O Bees/Wasps
O Formaldehyde
O Aluminum
O Neomycin
O Gelatin
O Thimerosol/Mercury
O 2-phenoxyethanol
O Sulfa drugs

**MEDICATION ALLERGIES:**

Please list any other medication allergies:_____

_____

**MEDICATIONS:**

Please list all the medications/injections you are currently taking, including over-the-counter medications, and vitamins and minerals: _____

_____

**VACCINATION HISTORY:**

Have you ever been vaccinated against or had any of the following diseases *(check all that apply):*

| | | |
|---|---|---|
| O Measles | O Mumps | O Rubella ("German Measles") |
| O Varicella (Chickenpox or Shingles) | O Polio | O Hepatitis A |
| O Hepatitis B | O Tetanus | O Pertussis |
| O Meningitis | O Rabies | O Pneumonia |
| O Influenza | O Yellow Fever | O Japanese Encephalitis |
| O Typhoid | | |

Ever had a bad reaction to a vaccine? O Yes O No
*If yes, please describe*: _____

_____

**MEDICAL HISTORY:**

Have you ever fainted form having your blood drawn or from an injection? . . . . . .O Yes O No

Do you have cancer, HIV/AIDS or any other immune disorder? . . . . . O Yes O No

Have you taken steroids (Prednisone, Medrol) within the past 6 months? . . . . . O Yes O No

Have you had any chemotherapy in the past 6 months? . . . . . .O Yes O No

Are you on Coumadin or warfarin? . . . . . .O Yes O No

Have you had or do you currently have any of the following:

-Fever in the last 48 hours . . . . . O Yes O No
-Cancer . . . . . .O Yes O No
-Arrythmia . . . . . O Yes O No
-Low platelet count/coagulation disorder/prior or current severe anemia . O Yes O No
-Heart disease . . . . . .O Yes O No
-Kidney disease . . . . . .O Yes O No
-Hepatitis/liver disease . . . . . .O Yes O No
-Bipolar disorder . . . . . O Yes O No
-Depression/anxiety . . . . . .O Yes O No

-Other psychiatric problems . . . . . O Yes O No
-Psoriasis . . . . . .O Yes O No
-Eye disease/condition . . . . . O Yes O No
-G6PD deficiency . . . . . .O Yes O No
-Convulsions/seizures/epilepsy . . . . . O Yes O No
-Asthma . . . . . .O Yes O No
-Diabetes . . . . . O Yes O No

-Other: _____

**FEMALE PATIENTS:**

Are you pregnant? . . . . . O Yes O No

Date of last menses: _____ / ____ / ____ or . . . . . .O Post-menopausal

Are you planning to become pregnant in the next year? . . . . . .O Yes O No O N/A

Are you breastfeeding? . . . . . .O Yes O No O N/A

Are you using birth control? . . . . . O Yes O No
*Method:* _____

**COMMENTS:**