USC Engemann
Student Health Center

Place Patient Label Here

Travel History Form

An online PDF version of this form is available at: engemannshc.usc.edu/forms. Complete form and email as an attachment to: uphctrvl@usc.edu

Name: _____ USC ID#.: _____

Address: _____

Birth Date: ____/____/____ (MM / DD / YY) Today's Date: ____/____/____ (MM / DD / YY) **Gender:** ☐ Female ☐ Male

Home Telephone No.: (_____) _____ Work Telephone No.: (_____) _____

E-Mail Address: _____ Do you have a current passport or visa? ☐ Yes ☐ No ☐ Dont' Know

Travel Specifics

Purpose of Trip: ☐ School Related Study/Work What school? _____

☐ Pleasure ☐ Business ☐ Other: _____

What will you be doing on this trip? _____

Does your program require the completion of a medical form by a practitioner? ..... ☐ Yes ☐ No

Are you currently enrolled in a health insurance plan that covers you while overseas? ..... ☐ Yes ☐ No

What insurance coverage do you currently have? _____

Do you have medical evacuation insurance? ..... ☐ Yes ☐ No

Departure Date from United States: _____ Return Date to United States: _____

Countries **AND** cities to be visited in order of visits	**Arrival Date** (MM/DD/YY)	**Departure Date** (MM/DD/YY)

A. Have you travelled outside the United States before? ☐ Yes ☐ No

If yes, where and when?: _____

B. Will you be:

Yes	No	
☐	☐	Visiting ONLY major cities? If no, explain: _____
☐	☐	Staying ONLY in Hotels? If no, explain: _____
☐	☐	Visiting friends and family?
☐	☐	Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains.
☐	☐	Working in the medical or dental field with exposure to blood or other body fluids?
☐	☐	Working with exposure to animals?
☐	☐	Potentially having sexual contact with new partners?

TRVHX 09/2013

Name: _____

USC 10-Digit ID Number: _____

Allergies

1. ☐ No known drug allergies ☐ No known Food allergies
2. Have you had an allergic reaction to any of the following? (please check all that apply)

☐ Eggs
☐ Sulfa Drugs (e.g., Bactrim, Septra, Gantrisin)
☐ Antibiotics (e.g., Neomycin, Streptomycin)
☐ Thimerosal (preservative in contact lens solution)
☐ Chrysanthemums
☐ Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxycholoroquine [Plaquenil], Primaquine)
☐ Pyrimethamine
☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin)
☐ Other: _____

Immunizations

1. Were you born in the United States? Yes ☐ No ☐ If no, where? _____
2. Have you completed the following immunizations? (*Please bring your vaccination record*)

Hepatitis A	☐ Yes	when: #1 _____ #2 _____	☐ No	☐ Not Sure
Hepatitis B	☐ Yes	when: #1 _____ #2 _____ #3 _____	☐ No	☐ Not Sure
Meningococcal Meningitis	☐ Yes	when: _____	☐ No	☐ Not Sure
MMR (Measles, Mumps and Rubela)	☐ Yes	when: _____	☐ No	☐ Not Sure
Polio Series	☐ Yes	when: _____	☐ No	☐ Not Sure
Tetanus	☐ Yes	when: _____	☐ No	☐ Not Sure
Typhoid	☐ Yes	when: _____	☐ No	☐ Not Sure
Yellow Fever	☐ Yes	when: _____	☐ No	☐ Not Sure
Other: _____		when: _____		

Medical History

1. Are you using steroids, receiving radiation therapy or other immunosuppressive chemotherapy? ☐ Yes ☐ No
2. List your current prescription medications and medical condition treated: (include birth control pills)

Current Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

3. List regularly used non-prescription medications (Over-the-counter, herbal, homeopathic, vitamins, etc.)

Regularly Used Non-Prescription Medications	Condition or Reason for Use
1.	
2.	
3.	

4. Have you been told you have any of the following medical conditions (check all that apply)?

Yes	No	Family History		Yes	No	Family History		Yes	No	Family History	
☐	☐	☐	Anemia	☐	☐	☐	G6PD Deficiency	☐	☐	☐	Liver Disease/Hepatitis
☐	☐	☐	Asthma	☐	☐	☐	Gout	☐	☐	☐	Lung Disease
☐	☐	☐	Blood Clotting Problems	☐	☐	☐	Hearing Problem	☐	☐	☐	Prostate Problems
☐	☐	☐	Cancer	☐	☐	☐	Heart Disease	☐	☐	☐	Psoriasis/Other Skin Problem
☐	☐	☐	Depression	☐	☐	☐	High Blood Pressure	☐	☐	☐	Psychiatric Problems
☐	☐	☐	Diabetes	☐	☐	☐	High Cholesterol	☐	☐	☐	Sickle Cell Disease
☐	☐	☐	Ear Infections Chronic or Frequent	☐	☐	☐	Hormone Problems	☐	☐	☐	Stomach Ulcer
☐	☐	☐	Epilepsy/Seizure Disorder	☐	☐	☐	Immune System Deficiency	☐	☐	☐	Stroke
☐	☐	☐	Eye Problems (Except glasses/contacts)	☐	☐	☐	Kidney Disease	☐	☐	☐	Thyroid Problems
								☐	☐	☐	Other:

5. (For Women Only)
   a. Last normal menstrual period: _____
   b. Are you, or could you possibly be, pregnant? ☐ Yes ☐ No
   c. Are you breast-feeding an infant? ☐ Yes ☐ No

Questions/Concerns

1. Please list additional questions or concerns that you might have regarding your travel? (i.e., Int'l. voltage requirements, currency exchange, dealing with seasickness, etc.) _____