



UNM Student Health & Counseling (SHAC)
MSC06 3870
1 University of New Mexico
Albuquerque NM 87131-0001
(505) 277-3136 Fax: (505) 277-2020

International Travel Questionnaire

Patient Information

Date: _____

Name (Last, First, MI):		UNM ID#	
Date of Birth:		Phone:	
Country of Origin:		Age:	
SHAC MR#:		<input type="checkbox"/> Student <input type="checkbox"/> Staff <input type="checkbox"/> Faculty	

PATIENT (PLEASE COMPLETE)

ITINERARY:

List in order the countries you plan to visit. Indicate the month during which you will travel and # of days you will spend in each country. Include countries **en route**.

NAME OF CITY/COUNTRY	Month/Year	Length of Stay
1.		
2.		
3.		
4.		
5.		

Date of departure from United States: _____ Total travel time to destination: _____
Date of departure from Albuquerque: _____

Check each travel category applicable to your trip:

- Affluent tourism (hotels in urban or resort areas, hostels, "pension," with minimal daytime rural travel)
 Business/Professional travel/International programs with the University
 Rural/Adventure travel
 Visiting friend &/or relatives

Activities in any of the following areas:

- Nurse, physician, or other allied health personnel Missionary Animal handler Water activities
 Anthropologist Spelunker High altitude trekking Cycling/motor bike
 Archaeologist Biologist Veterinarian OTHER _____

Ongoing medical conditions: _____ NONE

- Sickle cell disease or other anemia Asthma Ulcerative colitis or Crohn's disease
 Hepatitis or other liver disease Psoriasis Psychiatric disorder
 Diabetes (Insulin Tablets Diet only) Heart disease High blood pressure
 Splenectomy (spleen removed during operation) HIV infection Seizure disorder or epilepsy
 Duodenal or gastric ulcer Migraines Pregnancy
 OTHER _____

Medication: _____ NONE

Prescription: _____ Over-the-counter: _____ Supplement &/or herbal: _____

Allergy or reaction to any of the following: _____ NONE

- Eggs Penicillin Sun or heat exposure Seafood/Shellfish
 Vaccines Sulfa drugs Allergy injections Foods
 Insect bites OTHER _____

Do you carry or have used adrenalin (epinephrine) for emergencies such as insect bites or food allergies (e.g., shellfish)? Yes___ No___

SHAC Office Use Only

International Travel Questionnaire

Temp _____

C/C Travel

Medications/Supplements/Herbal

P _____

R _____

B/P _____

Weight _____

A: Travel Consultation

LMP _____

Allergies

P: Immunization/Review/Update
Safety/Precautions Discussed

IMMUNIZATION SCHEDULE

Immunizations	Check if advised	Date	Date	Date	Declined (Patient's Initials)	Anti-Malarial	Strength	Amount
						Diphtheria-Tetanus (DT or Td) Tdap		
Hepatitis A Titer <input type="checkbox"/>					2. Aralen	500 mg		
Hepatitis B Titer <input type="checkbox"/>					3. Malarone	250 mg/100 mg		
Twinrix					4. Doxycycline	100 mg		
Influenza								
Measles (Monovalent)								
Measles, Mumps & Rubella (MMR)								
Polio: Oral (OPV)		Completed:						
Polio: Injectable (IPV)								
PPD Pre-Travel								
PPD Post-Travel								
Varicella Vaccine								
Hx Dz _____ Titer								
Typhoid Inject								
Typhoid Oral								
Rabies Discussed _____ Titer								
Meningococcal								
Japanese Encephalitis								
Yellow Fever								
Pneumococcal								

Medications

- Ciprofloxacin 500 mg
- Rifaximin 200 mg

Review/Discussed/Handouts

- Travelers' Diarrhea
- Insect Protection
- Gen Travel Info/Safety
- Travelers' Insurance
- ETOH/Drugs

____ I've been informed about & have reviewed the required &/or recommended immunizations/medications as well as travel risks & safety prevention.

____ I hereby acknowledge refusal of above indicated vaccines and/or medications.

____ I may not have adequate time to receive optimal immunity for all of the immunizations I am receiving, and I am aware of the risks.

Patient Signature

Date

Practitioner Signature

Date