

Place Patient Label Here

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: / / Today's Date: / / Gender: Female Male
MM / DD / YY

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 <u>AND</u> 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)
- | | |
|---|---|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Quinines (Chloroquine [Aralen], Mefloquine [Lariam], Hydroxychloroquine [Plaquenil], Primaquine) |
| <input type="checkbox"/> Sulfa Drugs (e.g., Bactrim, Septra, Gantrisin) | <input type="checkbox"/> Pyrimethamine |
| <input type="checkbox"/> Antibiotics (e.g., Neomycin, Streptomycin) | <input type="checkbox"/> Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin) |
| <input type="checkbox"/> Thimerosal (preservative in contact lens solution) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chrysanthemums | |

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 | <input type="checkbox"/> Yes when: #1 _____ #2 _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Hepatitis B | <input type="checkbox"/> Yes when: #1 _____ #2 _____ #3 _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Meningococcal Meningitis | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| MMR (Measles, Mumps and Rubela) | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Polio Series | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Tetanus | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Typhoid | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| Yellow Fever | <input type="checkbox"/> Yes when: _____ | <input type="checkbox"/> No | <input type="checkbox"/> 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 | |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | G6PD Deficiency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood Clotting Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis/Other Skin Problem |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear Infections Chronic or Frequent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hormone Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immune System Deficiency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems (Except glasses/contacts) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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.) _____