

Kansas State University
Lafene Health Center
1105 Sunset Ave.
Manhattan, KS 66502
Phone 785-532-6544
Fax 785-532-3425

TRAVELERS' CLINIC QUESTIONNAIRE

Today's Date _____

Travel Clinic visits require an appointment. An initial travel appointment should be scheduled either by calling 532-6544 or by stopping at the appointment desk.

YOU MUST BRING THIS COMPLETED FORM WITH YOU FOR YOUR APPOINTMENT.

PLEASE PRINT LEGIBLY

Name _____ Birth Date _____
Last First Middle

() Student () Faculty/staff () Other Soc. Sec. # _____

Address: (Local) _____ (Permanent) _____

Phone (Home) _____ (Office) _____

Current Medications: _____

Are you being treated for leukemia, lymphoma, cancer, or any other malignant diseases? yes or no

Do you have a history of a deficiency of the immune system? yes or no

Do you have a history of anemia or any other blood disorder? yes or no

Do you have any existing medical condition such as diabetes, heart disease, or pulmonary disease?
yes or no If yes, please list: _____

Are you taking any steroids? yes or no

Do you have impaired gastric defenses (such as frequent diarrhea) or use antacids frequently? yes or no

Have you had allergic reactions to any of the following items? (Circle all that apply.)

Eggs Mercury (thimerosal) Bee stings Formaldehyde Sunlight

Are there any medications or vaccinations that cause you to have an allergic reaction?

yes or no If yes, please list:

Do you have any history or psychiatric disorders (such as depression, panic attacks, psychosis, etc.) or neurological disorders?

yes or no

FOR WOMEN ONLY:

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? yes or no

Are you breast-feeding? yes or no

TRAVEL INFORMATION

Organization associated with travel? _____ Group Director _____

Date of departure _____ Date of return _____

Please indicate the countries you will be visiting in the order in which you will visit them. Also indicate the length of stay in each country.

DESTINATION	LENGTH OF STAY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle all that apply to your travel plans:

- | | | |
|--------------------------|--------------|--------------------|
| Major resort hotels | Cruise ships | Camping |
| Staying with a family | Small hotels | Safari |
| Rented foreign home | Youth hostel | Outdoor activities |
| Rural travel at any time | Spelunking | Dormitories |
| Other _____ | | |

Are you traveling alone? with a group? or both? Circle the answer.

Please circle all the vaccines that you have had in the past and list the date of the most recent vaccination if known:

- | | |
|----------------------------|------------------------------|
| Cholera | Yellow fever |
| Hepatitis B | Tetanus-diphtheria |
| Rabies | Immune globulin |
| Typhoid-oral or injectable | Hepatitis A vaccine (Havrix) |
| Polio-oral or injectable | Influenza |
| Meningococcal | Pneumococcal |
| Malaria drugs | Plague |
| Measles-mumps-rubella | Japanese encephalitis |

PLEASE BRING IMMUNIZATION RECORDS WITH YOU AT THE TIME OF YOUR FIRST APPOINTMENT!