UNIVERSITY HEALTH SERVICES

International Travel Assessment

Patient Name:_____ Date:_____ CWID#_____ Phone Number_____

Email:_____ Preferred Appointment Time(s)_____

1. Travel Destination(s) (attach itinerary if available): _____

2. Rural ☐ City ☐ 3. Spending the night outside an urban area? YES NO

4. Departs:_____ Returns:_____

5. Have you ever traveled before? YES NO If yes, have you been treated at OSU? YES NO

6. Have you ever taken anti-malaria drugs? YES NO

7. Have you ever had a reaction to an anti-malarial drug? If so, please list the reaction._____

8. Would you like a prescription for an anti-diarrheal or any other medicine? YES NO

If so, list: _____

HISTORY

Please check each item yes or no; if yes, write "C" if the problem still exists.

Have you had?	yes	no	Have you had?	yes	no	Have you had?	yes	no	Have you had?	yes	no
Arthritis			High BP			Kidney Disease			Meningitis		
Anemia			Heart disease			Urinary stones			Mononucleosis		
Bleeding disorder			Stroke			Diabetes			Pneumonia		
Allergies/hayfever			Epilepsy/seizure			Thyroid disease			Tuberculosis		
Asthma			Liver disease			Chicken pox			Stomach ulcer		
Depression			Headaches			High cholesterol			Cancer		
Emphysema/COPD			Hepatitis			Measles					

9. Please list any allergies:_____

10. Current Medications (*please include prescription medications, over-the-counter medications, and herbals/home remedies)*:_____

_____

11. Immunization History (please list SPECIFIC DATES, month/year):

Routine/MMR_____ Polio_____ Hepatitis A_____

Hepatitis B_____ Tetanus (Td)_____

** Specific documentation of immunizations must be provided to the staff at University Health Services. Please bring any documentation with you to your appointment.

Please complete and fax this form to 405-744-6556 or email it to uhs@okstate.edu.

After receiving your form, we will contact you to schedule any necessary appointment(s).