



USC-University Park Health Center  
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# Travel History Form

An pdf online version of this form may be completed at: [www.usc.edu/uphc](http://www.usc.edu/uphc) (*click forms*) and e-mailed as an attachment to: [uphctrvl@usc.edu](mailto:uphctrvl@usc.edu)

Name: \_\_\_\_\_ 10-Digit USC ID No. : \_\_\_\_\_

Address: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

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	Departure Date

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?

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.)
- \_\_\_\_\_