Stanford | Environmental Health & Safety
Occupational Health Center

484 Oak Road
Stanford, CA 94305-8007
Phone: 650.725.5308
FAX: 650.725.9218
suohc.stanford.edu

TRAVEL QUESTIONNAIRE

Name (Print):		Today's Date:
Department/Supervisor:	SU ID#:	Work #:

TRAVEL INFORMATION

Departure Date _____ **Return Date _____**

Destination #1

Country _____

City _____

Days in City____ _____

Destination #2

Country _____

City _____

Days in City____ _____

Destination #3

Country _____

City _____

Days in City____ _____

Destination #4

Country _____

City _____

Days in City____ _____

Destination #5

Country _____

City _____

Days in City____ _____

Destination #6

Country _____

City _____

Days in City____ _____

Please check activities that may apply:

☐ Traveling to high altitude?

For how many days? _____ To what altitude?_____

☐ Visiting rural areas ☐ Freshwater swimming ☐ Ocean swimming ☐ Diving

☐ Safari ☐ Other animal contact ☐ Strenuous hiking ☐ Eating street foods

Please describe the work tasks (and other actions) you will be performing during travel

_____

_____

_____

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General Medical History

	YES	NO	Please Describe
Have you had a fever in the past 48 hours?			
Is your immune system compromised because of a disease or treatment for a disease?			
Do you have thrombocytopenia (low platelet count) or another blood coagulation disorder?			
Do you have any stomach or intestinal conditions?			
Have you ever had hepatitis or yellow jaundice?			
Have you currently/previously experienced any illness related to your thymus?			
Have you had your spleen or appendix removed?			
Are you prone to motion sickness?			
(Female only) Are you pregnant/ trying to become pregnant?			First day of last menstrual period:
(Female only) Are you currently breastfeeding?			

Do you have any existing medical conditions such as diabetes, heart disease, lung disease or sleep apnea?

_____

_____

Do you have a medical condition that is stable now but which may recur while traveling?

_____

_____

_____

Please list any other significant medical conditions you have had within the last 5 years. If you answered yes to any of the above questions and need additional space, please also explain.

_____

_____

_____

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Medications

Are you currently taking any of the following medications:

☐ Chloroquine, Mefloquine, or Proguanil to prevent malaria? _____

☐ Steroids, prednisone, cortisone, or anti-cancer drugs? _____

☐ Antibiotics? _____

☐ Pepto-Bismol or antacids? _____

☐ Oral contraceptives? _____

☐ Aspirin? _____

Please list any other medications you take on a dally or occasional basis

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies

Are you allergic or hypersensitive (shortness of breath, hives, anaphylaxis, rash, etc) to any of the following:

☐ Penicillin? ☐ Sulfa? ☐ Mercury or Thimerosal?

☐ Sulfites? ☐ Amphotericin B? ☐ Yeast?

☐ Bee stings ☐ Eggs? ☐ Gelatin

☐ Beef protein, soy, casein, lactose, phenol, or formaldehyde ☐ Streptomycin?

Any allergies or hypersensitivities not previously listed? _____

_____

Please describe reaction, if any _____

Do you carry emergency medical ID? _____

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Immunizations

Have you ever had any reactions or side effects from any vaccination?

If yes, please explain:_____

Have you been administered immune globulin or any blood product during the past year? _____

Have you been administered malaria (prophylaxis) medication in the past?

Medication used_____ Side effects _____

Please email (stanfordohc@stanford.edu) or FAX (650-725-9218) us a copy of your immunization history, including the following immunizations:

Hepatitis A

Hepatitis B

Japanese Encephalitis

Meningococcal

MMR

Pneumococcal

Polio

Rabies

Tetanus (Td or Tdap)

Typhoid

Varicella

Influenza

Yellow Fever