# TRAVEL QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Name (Print):</th>
<th>Today’s Date:</th>
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<tbody>
<tr>
<td>Department/Supervisor:</td>
<td>SU ID#:</td>
</tr>
<tr>
<td></td>
<td>Work #:</td>
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## TRAVEL INFORMATION

<table>
<thead>
<tr>
<th>Departure Date</th>
<th>Return Date</th>
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### 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
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
### General Medical History

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Please Describe</th>
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<tr>
<td>Have you had a fever in the past 48 hours?</td>
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<td>Is your immune system compromised because of a disease or treatment for a disease?</td>
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<td>Do you have thrombocytopenia (low platelet count) or another blood coagulation disorder?</td>
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<td>Do you have any stomach or intestinal conditions?</td>
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<td>Have you ever had hepatitis or yellow jaundice?</td>
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<td>Have you currently/prevously experienced any illness related to your thymus?</td>
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<td>Have you had your spleen or appendix removed?</td>
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<td>Are you prone to motion sickness?</td>
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<tr>
<td>(Female only) Are you pregnant/trying to become pregnant?</td>
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<td>First day of last menstrual period:</td>
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<td>(Female only) Are you currently breastfeeding?</td>
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<td>Do you have any existing medical conditions such as diabetes, heart disease, lung disease or sleep apnea?</td>
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<td>Do you have a medical condition that is stable now but which may recur while traveling?</td>
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<td>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.</td>
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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 daily or occasional basis:

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### Allergies

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

- [ ] Penicillin?
- [ ] Sulfites?
- [ ] Bee stings
- [ ] Beef protein, soy, casein, lactose, phenol, or formaldehyde

- [ ] Sulfur?
- [ ] Amphotericin B?
- [ ] Eggs?
- [ ] Streptomyacin?
- [ ] Mercury or Thimerosal?
- [ ] Yeast?
- [ ] Gelatin

Any allergies or hypersensitivities not previously listed?

Please describe reaction, if any

Do you carry emergency medical ID?
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