Student Health Services
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-4325
FAX: 619-594-3638
http://shs.sdsu.edu

SDSU San Diego State University

CONFIDENTIAL
The information you provide will be used to assist in your care at Student Health Services

TRAVEL MEDICINE CLINIC FORM

Please complete the form and bring it and your immunization record to your appointment.

NAME: _____ DATE: _____ RED ID: _____

Departure Date: _____/_____/_____

Reason(s) for travel/purpose: ❑ Education ❑ Tourism ❑ Research ❑ Volunteering or Missions
❑ Visiting Friends, Family and/or Relatives ❑ Other: _____

Countries/Regions to be visited in order:	Duration of Stay (for each country)	Going outside main tourist areas?
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No

Date of Return: _____/_____/_____

Accommodation: ❑ Hotel ❑ Home ❑ Dorm ❑ Hostel
❑ Cruise Ship ❑ Other: _____

Activities: ❑ Scuba/Snorkeling ❑ Swimming ❑ Raft/Kayak ❑Jogging ❑ Camping
❑ Trek/Climbing ❑ Safari ❑ Cycling ❑ Animal Handling/Caving
❑ High Altitude* (if yes, see below) ❑ Providing Health/Dental Care
❑ New Sexual Partner ❑ Other: _____

*Will you be traveling above 8000 feet? ❑ Yes ❑ No
*Have you ever had altitude sickness? ❑ Yes ❑ No

Travel History- List all countries visited in the past 5 years:

_____

_____

Are you taking any daily medications?
If yes, please list: _____ ❑ Yes ❑ No

Do you have any chronic medical conditions (including psychological disorders or seizures), or history of a disease or treatment that may have affected your immune system function? ❑ Yes ❑ No ❑ Unsure
If yes, please describe: _____

Student Health Services
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-4325
FAX: 619-594-3638
http://shs.sdsu.edu

SDSU | San Diego State University

CONFIDENTIAL
The information you provide will be used to assist in your care at Student Health Services

During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug? ❑ Yes ❑ No ❑ Unsure
If yes, please describe: _____

Do you have allergies to medications, foods, vaccine components (including eggs, gelatin or neomycin), latex or stinging insects? ❑ Yes ❑ No ❑ Unsure
If yes, please describe: _____

For biological females: Are you pregnant, trying to become pregnant or breastfeeding? ❑ Yes ❑ No ❑ Unsure
If yes, please describe: _____

Please List Dates From Your Immunization Record Below:

		PROVIDER USE ONLY	
		Series Complete?	Booster Needed?
Tetanus (DT, Td, Tdap)	____ ____ ____ ____ ____ ____ ____	Y N	Y N
Hepatitis A	____ ____	Y N	
Hepatitis B	____ ____ ____	Y N	
Hepatitis A & B combo	____ ____ ____	Y N	
Influenza (most recent only)	____ ____		
Polio (IPV/OPV)	____ ____ ____ ____ ____	Y N	Y N
Japanese Encephalitis	____ ____ ____ ____	Y N	Y N
Meningococcal (MCV4)	____ ____ ____ ____	Y N	Y N
Pneumococcal (PCV7 or 13)	____ ____ ____ ____	Y N	
Pneumococcal (PPSV23)	____ ____	Y N	Y N
Rabies	____ ____ ____	Y N	
Typhoid (injectable)	____ ____ ____	Y N	Y N
Typhoid (Oral)	____ ____ ____	Y N	Y N
MMR (measles/mumps/rubella)	____ ____	Y N	
Varicella (chickenpox) ❑ Had chickenpox	____ ____	Y N	
Yellow Fever	____ ____ ____	Y N	Y N