GEORGE MASON UNIVERSITY | Student Health Services

Travel Clinic:
Pre-Travel Assessment Form

1. Complete this form prior to your Travel Clinic appointment.

2. Bring this completed form to your Travel Clinic Appointment.

3. Prior to your Travel Clinic appointment, review the CDC Healthy Travel website (www.cdc.gov/travel) to familiarize yourself with both general travel/safety recommendations, and those specific to the area(s) you plan to visit.

4. For any questions about this form or Travel Clinic appointments contact Student Health Services at 703-993-2831.

Last Name _____ **First Name** _____ **G #** _____

Dates of Travel

Departure Date _____ Return Date _____

Trip Itinerary or Travel Destinations

	Country	City/Area	Length of Stay
1.			
2.			
3.			
4.			
5.			
6.			

Check the descriptions in each category below that best represent your travel plans

1. Type of Trip (check all that apply):

- ☐ Business
- ☐ Pleasure
- ☐ Package/Group
- ☐ Cruise Ship
- ☐ Guided/escorted
- ☐ Humanitarian (please describe) _____
- ☐ Other (please describe) _____

2. Planned Activities (check all that apply):

- ☐ Working in a medical or dental field
- ☐ Working with animals or birds
- ☐ Outdoor activities (for example hiking or camping)
- ☐ Snorkeling or scuba diving
- ☐ Safari
- ☐ Other (please describe) _____

3. I will be staying in an area that is (check all that apply):

- ☐ Urban
- ☐ Rural
- ☐ High Altitude
- ☐ Other (please describe) _____

4. Accommodations (check all that apply):

- ☐ Modern hotel
- ☐ Youth hostel
- ☐ With a local family
- ☐ With relatives
- ☐ Tent or cabin
- ☐ Other (please describe) _____

5. I will be traveling (check all that apply):

- ☐ Alone
- ☐ With family or friends
- ☐ With a group
- ☐ Other (please describe) _____

Personal Medical Information

Check if you have or have had any of the following (select all that apply):

☐ Heart Disease	☐ Liver or Kidney Problems	☐ Autoimmune Disorder
☐ High Blood Pressure	☐ Diabetes	☐ Asthma/COPD/Emphysema
☐ Blood Disorder	☐ Seizures or Epilepsy	☐ Recurrent Pneumonia
☐ Blood Clots/Phlebitis	☐ Psychiatric problems	☐ Previous travel-related illness
☐ G6PD Deficiency	☐ Splenectomy	☐ Severe reaction to a vaccine

☐ Any conditions treated with immunosuppressive drugs such as: cancer, organ transplant, rheumatoid arthritis, ulcerative colitis, lupus, HIV etc...

☐ Any other medical problem that suppresses your immune system: (please describe) _____

☐ Other medical problem(s): (please describe) _____

☐ None of the above apply to me

Current Medications

List any medications you are currently taking, include prescriptions, over-the-counter medications, birth control, vitamins, supplements, etc...

☐ I am not currently taking any medications

	Medication	Reason		Medication	Reason
1.			2.		
3.			4.		
5.			6.		
7.			8.		

Immunization History

Indicate if you have received any of the following vaccinations and the date of immunization

Vaccine	Date of last immunization	Vaccine	Date of last immunization
Hepatitis A		Polio	
Hepatitis B		Rabies	
Hepatitis A & B (Twinrix)		Td (tetanus)	
Japanese Encephalitis		TdaP (Td & pertussis)	
Meningococcal		Typhoid (pill or shot)	
MMR Measles/Mumps/Rubella		Varicella (Chickenpox)	
Pneumonia		Yellow Fever	

For immunization history, information and assistance please call the Student Health Immunization Office at 703-993-2135.

To the best of my knowledge, the above information I have provided about my medical history is correct.

Signature _____ Date _____

Print Form