

**UNIVERSITY HEALTH SERVICES (UHS)
 PATIENT REGISTRATION FOR TRAVEL**

Date	Print Name (Last, First)	Penn State Student ID Number	DOB	
GENERAL MEDICAL (Continued)		YES	NO	PROBLEM*
	Have you had a fever in the past 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Td, Influenza, Meningococcal, Oral typhoid, Pneumococcal (PPV), Tdap, MMRV
	Are you pregnant* or might you become pregnant on this trip? First day of your last period? _____	<input type="checkbox"/>	<input type="checkbox"/>	MMR or components, Oral typhoid, Smallpox, Varicella, Yellow fever, MMRV, Influenza (FluMist™), Zoster Vaccine Live (Zostavax), HPV (Gardasil), Doxycycline and other antibiotics. For other immunizations weigh the theoretical risk of vaccination against the risk of disease.
	Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	MMR or components, Oral typhoid, Smallpox, Rabies, Varicella, Yellow fever, Influenza (FluMist™), MMRV, Zoster Vaccine Live (Zostavax)
	Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?	<input type="checkbox"/>	<input type="checkbox"/>	Yellow fever
	Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Any intramuscular injection
	Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine, DTaP, Tdap, MMRV
	Do you have any stomach conditions?	<input type="checkbox"/>	<input type="checkbox"/>	Oral typhoid, Mefloquine, Doxycycline
	Do you have a G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	Chloroquine, Primaquine
	Do you have severe renal impairment?	<input type="checkbox"/>	<input type="checkbox"/>	Malarone
	Do you have bowel conditions such as diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus
	Have you ever had hepatitis or yellow jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have a history of psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
	Do you have a problem with strange dreams and/or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
	Do you have insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
	Do you have problems with vaginitis?	<input type="checkbox"/>	<input type="checkbox"/>	Any antibiotic
	Do you have psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Chloroquine or related compounds
	Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis (e.g., itchy, red, scaly rash lasting > 2 weeks that often comes and goes)?	<input type="checkbox"/>	<input type="checkbox"/>	Smallpox
	Cardiac disease, with or without symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	Smallpox, Influenza (FluMist™)
	Do you have any eye conditions?	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICATIONS	YES	NO	PROBLEM*
ARE YOU TAKING OR WILL YOU BE TAKING:			
Quinine, quinidine or medications for a cardiac conduction defect?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine
Chloroquine, mefloquine, or proguanil to prevent malaria?	<input type="checkbox"/>	<input type="checkbox"/>	
Proguanil to prevent malaria	<input type="checkbox"/>	<input type="checkbox"/>	Oral typhoid
Steroids, prednisone, cortisone or anti-cancer drugs?	<input type="checkbox"/>	<input type="checkbox"/>	MMR or components, Oral typhoid, Varicella, Yellow fever, Influenza (FluMist™), MMRV, Zoster Vaccine Live (Zostavax)
Antibiotics or sulfonamides?	<input type="checkbox"/>	<input type="checkbox"/>	Oral typhoid
Pepto-Bismol to prevent travelers' diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	Doxycycline, tetracycline

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ARE YOU TAKING OR WILL YOU BE TAKING:				
Antacids?	<input type="checkbox"/>	<input type="checkbox"/>		Doxycycline, tetracycline
Oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>		Doxycycline, tetracycline
Aspirin therapy (children and adolescents)	<input type="checkbox"/>	<input type="checkbox"/>		Varicella, Influenza (FluMist™)
Medications for emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>		Mefloquine
Medications for convulsions?	<input type="checkbox"/>	<input type="checkbox"/>		Mefloquine
ALLERGIES		YES	NO	PROBLEM*
ARE YOU ALLERGIC TO:				
Any medications? _____	<input type="checkbox"/>	<input type="checkbox"/>		
Amphotericin B?	<input type="checkbox"/>	<input type="checkbox"/>		Rabies (PCEC)
Penicillin or sulfa?	<input type="checkbox"/>	<input type="checkbox"/>		Diamox®, Fansidar®, Penicillin, Sulfa
Mercury or thimerosal? (Only vaccines containing more than a trace amount of thimerosal are listed).	<input type="checkbox"/>	<input type="checkbox"/>		DT (multi-dose), Tetanus toxoid (multi- dose; booster), Influenza (Fluzone multi- dose; Fluvirin), Japanese encephalitis, Meningococcal (Menomune multidose).
Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A/B (Twinrix®), Influenza, IPV, MMR or components, Rabies [HDCV and PCEC], Varicella, Smallpox, PEDIARIX™, MMRV, TBE, Zoster Vaccine Live (Zostavax)
Polymyxin?	<input type="checkbox"/>	<input type="checkbox"/>		Influenza, (Fluvirin™), IPV, Smallpox; PEDIARIX™.
Sulfites?	<input type="checkbox"/>	<input type="checkbox"/>		Doxycycline
Aluminum or aluminum hydroxide?	<input type="checkbox"/>	<input type="checkbox"/>		Hep. A, Hep. B, Hep A/B (Twinrix®) COMVAX™, DTaP, Td, Rabies (RVA), Anthrax, Pneumococcal (PCV), Tdap, TBE, HPV (Gardasil)
Benzethonium chloride?	<input type="checkbox"/>	<input type="checkbox"/>		Anthrax
2-phenoxyethanol?	<input type="checkbox"/>	<input type="checkbox"/>		Hep. A (Havrix®), Hep. A/B (Twinrix®), IPV, DTaP, (Infanrix™, PEDIARIX™), Tdap (ADACEL™)
Bee stings, or history of hives or urticaria?	<input type="checkbox"/>	<input type="checkbox"/>		Japanese encephalitis
Yeast?	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B, Hepatitis A/B (Twinrix®), PEDIARIX™, HPV (Gardasil)
Eggs?	<input type="checkbox"/>	<input type="checkbox"/>		Influenza, Rabies (PCEC), Yellow fever, MMR or components, MMRV, TBE
Glycerin or chlortetracycline?	<input type="checkbox"/>	<input type="checkbox"/>		Smallpox
Are you hypersensitive to gelatin?	<input type="checkbox"/>	<input type="checkbox"/>		Varicella, Japanese encephalitis, MMR or components, DTaP, Yellow fever, Rabies (PCEC), Influenza (Fluzone), Oral typhoid, MMRV, Zoster Vaccine Live (Zostavax)
Are you hypersensitive to beef protein, soy, casein, lactose, phenol, or formaldehyde?	<input type="checkbox"/>	<input type="checkbox"/>		IPV, Meningococcal, Typhoid, Rabies, DTaP, Pneumococcal (PPV), Anthrax, Smallpox, Tdap, MMRV, Rotavirus, TBE

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*Note: Any “problem” listed may be a contraindication or merely a precaution that warrants further discussion between the health care provider and patient. The problems listed are not all inclusive: for example, during pregnancy the health care provider must weigh the theoretical risk of vaccination against the risk of disease.

COMMENTS: _____

SIGNATURE OF TRAVELER: _____ DATE: _____

SIGNATURE OF HEALTH CARE PROVIDER: _____ DATE: _____

The information in this questionnaire is not a substitute for medical advice from a health care provider on an individual basis.