TRAVEL HEALTH ASSESSMENT

Name:_____
First Middle Last

E-Mail Address:_____

Gender: ☐ Female ☐ Male Date of Birth: _____/_____/_____ Age: _____

If child is a minor, Parent/Guardian Name:_____

Address:_____

City:_____ State:_____ Zip:_____ County:_____

Daytime Phone:_____ Other Phone:_____

RACE
- ☐ Am Indian/Alaskan Native
- ☐ Arabic
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Family Physician/Phone #:_____

Destination(s):_____ **Departure Date:** _____/_____/_____ **Length of Stay:**_____

Reason for Travel: _____ **Pleasure** _____ **Business** _____ **Mission** _____ **Other:**_____

HEALTH QUESTIONS

Are you well today? ____ Yes ____ No

Have you been ill recently? ____ Yes ____ No

Fever? ____ Yes ____ No

Have you had any shots in the past month? If YES, what:_____ ____ Yes ____ No

Have you had any injection of immune globulin or other blood product in the past 8 months? ____ Yes ____ No

WOMEN: Are you pregnant or breastfeeding? ____ Yes ____ No

Please check the boxes if you have had any of the following conditions:

☐ Heart Problems	☐ High Blood Pressure	☐ Neurological Disease	☐ Stomach Problems
☐ Diabetes	☐ Kidney Disease	☐ Cancer	☐ Leukemia
☐ Lymphoma	☐ HIV/AIDS	☐ Lung Disease	☐ Liver Disease
☐ Eye Conditions	☐ Psoriasis	☐ Problems with Immune System	

Medications you are taking:_____

Are you on a long term aspirin therapy? ____ Yes ____ No

Do you have a history of seizures or convulsions? ____ Yes ____ No

Have you ever had hepatitis or yellow jaundice? ____ Yes ____ No

Have you ever fainted from having your blood drawn or from a shot? ____ Yes ____ No

Have you ever had a bad reaction to a vaccination? ____ Yes ____ No

Do you have a problem with nightmares? ____ Yes ____ No

Insomnia? ____ Yes ____ No

Do you have any bowel conditions, such as diarrhea or constipation? ____ Yes ____ No

Do you have medical or surgical conditions that need maintenance medications for which you have to see a physician regularly? ____ Yes ____ No

Have you had any medical conditions that are stable now, but which may recur while traveling? ____ Yes ____ No

Do you have severe thrombocytopenia (low blood platelet count) or a blood disorder? ____ Yes ____ No

Have you had your spleen removed? ____ Yes ____ No

Allergies (please check if you are allergic to any of the following)

☐ Eggs	☐ Gelatin	☐ Yeast	☐ Chicken
☐ Sulfates	☐ Mercury or Thimerosal	☐ Neomycin, Polymyxin Streptomycin	☐ Other:_____

Medication

Are you taking antibiotics? ____ Yes ____ No

Are you taking heart medications (esp. beta-blockers, quinidine, quinine)? ____ Yes ____ No

COMMENTS:

I certify that the above information is true and accurate to the best of my knowledge.

I authorize my immunization information to be submitted to the Michigan Immunization Registry where I will have access to obtain my immunization status through my medical provider. Upon receipt of a written request from an individual who is 20 years of age or older, the department shall make any immunization information in the registry pertaining to that individual inaccessible.

I understand an HIV (AIDS virus) test or other blood tests may be performed upon me without written consent if a health professional or other health facility employee sustains a skin cut, mucous membrane, or open exposure to my blood or other body fluids during the course of this visit. (Ref: Public Health Code PA368 of 1978, Section 333.5133 as amended 1988)

_____ _____

Signed Date

Kalamazoo County Health & Community Services

The Health & Community Services programs are open to all without regard to race, color, national origin, sex or disability.