STANFORD UNIVERSITY

ENVIRONMENTAL HEALTH & SAFETY
Occupational Health Center

480 Oak Road
Stanford, CA 94305-8007
Phone: 650.725.5308
FAX: 650.725.9218
ehs.stanford.edu

TRAVEL QUESTIONNAIRE

Name (Print):		Today's Date:
Department/Supervisor:	SU ID#:	Work #:

TRAVEL INFORMATION

Departure Date ____________ **Return Date ______________**

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

____

____

____

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General Medical History

	YES	NO	Please Describe
Have you had a fever in the past 48 hours?			
Is your immune system compromised because of a disease or treatment for a disease?			
Do you have thrombocytopenia (low platelet count) or another blood coagulation disorder?			
Do you have any stomach or intestinal conditions?			
Have you ever had hepatitis or yellow jaundice?			
Have you currently/previously experienced any illness related to your thymus?			
Have you had your spleen or appendix removed?			
Are you prone to motion sickness?			
(Female only) Are you pregnant/ trying to become pregnant?			First day of last menstrual period:
(Female only) Are you currently breastfeeding?			

Do you have any existing medical conditions such as diabetes, heart disease, lung disease or sleep apnea?

____

____

Do you have a medical condition that is stable now but which may recur while traveling?

____

____

____

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.

____

____

____

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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 dally or occasional basis

__________________________ __________________________ ________________________

__________________________ __________________________ ________________________

__________________________ __________________________ ________________________

__________________________ __________________________ ________________________

__________________________ __________________________ ________________________

Allergies

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

☐ Penicillin?	☐ Sulfa?	☐ Mercury or Thimerosal?
☐ Sulfites?	☐ Amphotericin B?	☐ Yeast?
☐ Bee stings	☐ Eggs?	☐ Gelatin
☐ Beef protein, soy, casein, lactose, phenol, or formaldehyde		☐ Streptomycin?

Any allergies or hypersensitivities not previously listed? ____

____

Please describe reaction, if any ____

Do you carry emergency medical ID? ____

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Immunizations

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 complete your immunization history as best as possible, entering dates on the lines provided

Hepatitis A

#1 ____________________ #2 ____________________ #3 ____________________ (TwinRix)

Hepatitis B

#1 ___________ #2 ___________ #3 ___________ #4 ___________ #5 ___________ #6 ___________

Japanese Encephalitis

#1 ____________________ #2 ____________________ #3 ____________________

Meningococcal #1 ____________________ #2 ____________________

MMR #1 ____________________ #2 ____________________

Pneumococcal #1 ____________________ #2 ____________________

Polio #1 ___________ #2 ___________ #3 ___________ #4 ___________ #5 ___________ #6 ___________

Rabies #1 ___________ #2 ___________ #3 ___________ #4 ___________

Tetanus Date of last immunization _______________________

Have you received a ☐ Tdap (for pertussis/whooping cough) since 2004? ☐ uncertain

Typhoid Oral (pills) ____________________ Vi (Injectable) ____________________

Varicella #1 ____________________ #2 ____________________

Yellow Fever Date of last immunization ____________________