

Travel Consult Questionnaire Instructions

For a safe and healthy trip, please schedule your travel consult appointment at least 4-6 weeks before departure. The Travel Consult form should be completed at least 72 hours before a Travel Consult Appointment is scheduled. We provide a country specific travel packet which includes food/water/insect precautions/health and safety guide, travel vaccines, and prescriptions, if needed.

- **Please complete Travel Consult Questionnaire**
 - Turn in your completed Travel Consult Questionnaire Form directly to the SWC **OR** upload the Travel Consult Questionnaire Form in your SWC patient portal under Downloadable Form **OR** fax the form to the SWC at (408) 924-7786. After the Travel Consult Questionnaire Form has been sent to the SWC, call (408) 924-5678 to schedule an appointment.

- **Bring all your immunization records to the appointment**

- **Vaccines available at the clinic:**
 - Hepatitis A and B
 - Influenza
 - Men ACWY (meningococcal)
 - MMR
 - Td (tetanus)
 - Tdap (tetanus/diphtheria/acellular pertussis)
 - Typhoid
 - Varicella

*** Call (408) 924-5678 for an appointment and for questions regarding fees or visit our website <https://sjsu.edu/wellness/> ***

Travel Consult Questionnaire Form

Name: _____ Student ID# _____

Medical History: Please check all that apply:

1. Have you ever had reactions to immunizations/travel vaccines? Yes No

2. Do you have allergies to the following items? (check all that apply)
 Eggs Neomycin Antibiotics Mercury Vaccines Bee Stings

3. Are there any other drugs to which you have had an allergic reaction? (Please List) _____

4. List all the medications you are taking _____

5. Do you have any of the following? Please check all that apply:

- | | |
|---|-----------------------|
| Thymus disease or history of thymectomy | Asthma/Lung disease |
| Immune system disorder or taking immune suppressive medications | Heart Arrhythmias |
| Cancer or blood disorder | Psoriasis |
| Anxiety, Depression, or other psychiatric disorder | Seizure or Epilepsy |
| Severe kidney impairment | Chronic liver disease |
| Pregnant | Diabetes |
| Possible pregnancy in next 3 months | Breastfeeding |

Reasons for travel: Education Pleasure Research Volunteer (i.e.,medical)

TRAVEL INFORMATION: Departure Date: _____ Return Date: _____

15. Please indicate in order of travel, the countries and cities you are traveling to:

Destination (City/Country)	Where will you stay?	Length of Stay	Rural Travel or Camping?	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

Please list any side or day trips planned _____

Will you be traveling above 8,000 feet? Yes No Do you plan to SCUBA dive? Yes No

16. Please check all the travel vaccines you have had:

- | | | | |
|--------------|-------------|-----------------------|-------------------------|
| Hepatitis A | Flu Vaccine | Pneumococcal Vaccine | Meningococcal(Men ACWY) |
| Hepatitis B | Polio | Measles/Mumps/Rubella | Typhoid |
| Yellow Fever | Rabies | Tetanus | J Japanese Encephalitis |

PLEASE BRING YOUR IMMUNIZATION RECORDS TO YOUR APPOINTMENT