Bowdoin College Travel Health Questionnaire

Name: _____ Date of Birth:_____ Age: _____

Address: _____

Email: _____ Phone: _____

Primary Care Provider/Phone: _____

Preferred Pronouns: _____

Travel Itinerary:

Departure Date: _____ Return Date: _____

Departing From: _____

Destinations (list all, including layovers and side trips): _____

_____

Returning From:_____

Travel Program/Organization**:** _____

Purpose of Travel: ☐ Study Abroad ☐ Leisure ☐ Business ☐ Visiting Friends / Relatives

☐ Volunteering ☐ Other: _____

Travel Activities: ☐ Tourism ☐ Camping/Backpacking ☐ Hiking/Trekking ☐ Biking ☐ Disaster Relief

☐ High-Altitude Activities ☐ Farming/Work with Animals ☐ Work in prisons or homeless shelters

☐ Work in medical setting ☐ Water-Based Activities (diving, swimming, rafting/boating) ☐ Solo/Independent

☐ Urban ☐ Rural ☐ Other: _____

Allergies: ☐ None ☐ Medications: _____

☐ Eggs ☐ Other Foods: _____

☐ Latex ☐ Bee/Wasp/Hornet Sting ☐ Other: _____

Type of Reaction: _____

Medications: *Please include birth control, herbal and over the counter medications taken regularly.*

Past & Current Medical History: ☐ None

☐ Heart Disease, Hypertension ☐ Bleeding or Clotting Disorder ☐ Neurologic Condition/Seizure Disorder ☐ Diabetes

☐ Lung Disease, Asthma ☐ Kidney Disease ☐ Cancer ☐ Skin Condition/Psoriasis/Eczema ☐ Liver Disease

☐ Immune Disorder ☐ Musculoskeletal Condition/Arthritis ☐ Stomach/Intestinal Problem ☐ Eating Disorder

☐ Eye Conditions/Glasses or Contacts ☐ Motion Sickness ☐ Transgender/Currently Transitioning

☐ Pregnant now/Planning pregnancy ☐ Breastfeeding now Date of last menstrual period: _____

Past & Current Mental Health History:

Have you been under the care of a psychiatrist, psychologist, therapist, or counselor in the past 3 years for any mental health or emotional condition? ☐ Yes ☐ No

If yes, please explain.

Do you experience travel-specific anxiety? _____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please explain.

Past & Recent Surgeries: ☐ None

Prior Travel Experience:

Have you traveled outside the United States? ☐ Yes ☐ No

If yes, where? _____

Prior experience with anti-malarial medication? ☐ Yes ☐ No If yes, what type? _____

Prior experience with altitude? ☐ Yes ☐ No If yes, any complications? _____

Any illnesses related to travel? _____

Other:

Do you regularly use substances: alcohol, tobacco, vaping products, marijuana/weed, other? _____

Do you have concerns about travel related to gender identity/sexual orientation? _____

Upon return would you be willing to provide brief feedback about your travel experiences via email? ☐ Yes ☐ No

Immunization History: *Please provide a copy of your complete immunization records.*

Have you had any immunizations in the past 3 weeks? ☐ Yes ☐ No

To my knowledge the above information is correct: _____

Signature Date Reviewed Date