Bowdoin College Travel Health Questionnaire

Name:_________________________________________________ Date of Birth:_______ Age:_____

Address:______________________________________________________________________________

Phone:___________________ Primary Care Provider/phone:___________________________________

**Type of Travel:** ☐ Study Abroad  ☐ Leisure   ☐ Business  ☐ Visiting Friends or Relatives

☐ Urban    ☐ Rural    ☐ Other __________________________________________

**Type of Housing:** ☐ Hotel   ☐ Friend or Relative’s home   ☐ Tent or open camping/backpacking

☐ Host Family ☐ Dorm ☐ Other __________________________

**Travel Itinerary:**

Departure date:_______________________________Return Date: ______________________________

Departing from _______________________________ Layover location(s)_________________________

Destination(s):_________________________________________________________________________

Returning from _______________________________ Layover location(s)_________________________

**Travel Activities:** ☐ Tourism   ☐ Camping   ☐ Hiking   ☐ Trekking   ☐ Farming   ☐ Diving

☐ Work in a medical setting ☐ Work in prisons or homeless shelters

☐ Work with animals ☐ Disaster relief ☐ Other_____________________

**Allergies:**  ☐ None

☐ Medications:________________________________________________________________________

☐ Eggs   ☐ Other Foods______________________________________________________________

☐ Latex   ☐ 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  ☐ Seizure Disorder  ☐ Diabetes

☐ Asthma  ☐ Kidney Disease  ☐ Pregnant now  ☐ Cancer

☐ Psoriasis  ☐ Liver Disease  ☐ Breastfeeding now  ☐ Immune disorder

☐ Arthritis  ☐ Stomach/Intestinal Problem  ☐ Eating Disorder  ☐ Other_________

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.

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?

Immunization History: ★ Please provide a copy of your immunization records ★

If you are a student, obtain a copy of these records from home. College records often include only entry requirements and vaccines received on campus. Send to Bowdoin College Health Services fax: 207-725-3905, Attn: Melody Faux, NP-C

Have you had any immunizations in the past 3 weeks?

☐ Yes  ☐ No

To the best of my knowledge the above information is correct:

______________________________  ________________  ________________  ________________
Signature                   Date                   Reviewed                   Date