UCF | Student Health Services

UNIVERSITY OF CENTRAL FLORIDA

International Health
Travel Clinic

Travel Clinic Evaluation Patient Worksheet

Please complete and bring printed copy with you to your appointment.

Destination(s): ____

Please list ALL cities and countries on your itinerary.

Accommodations: City Resort Rural Departure date from US: ________________

Length of Travel (# of days/nights): ____________ Return date to US: ____________________

Purpose of Trip

- Living/Working or study abroad/research *(Light activities)*
- Tourism/leisure recreation *(Moderately strenuous activities)*
- Adventure Recreation *(Very Strenuous)*
- Visiting Friends or Relatives
- Business
- Other ______________________

Accommodations

- Luxury hotel/resort
- Budget Hotel/Hostel
- Camping/Rustic Hut/Cabin
- Private Home
- Campus housing

Medical Conditions

- Asthma
- Cancer
- Diabetes
- Eating Disorder
- Seizures
- Heart Disease
- High Blood Pressure
- HIV / AIDS
- Immune Deficiencies
- Kidney/Liver Disease
- Psychiatric Disease
- Other ______________________

Prior Immunizations Dates *(mm/dd/yyyy)*

- COVID-19 __/__/____
- Hepatitis A __/__/____
- Hepatitis B __/__/____
- Influenza __/__/____
- Japanese Encephalitis __/__/____
- Meningitis __/__/____
- Polio __/__/____
- Tetanus __/__/____
- Typhoid __/__/____
- Yellow Fever __/__/____

Past surgical history: ____

Current Medical issues: ____

Current Medications and Dosages: ______________________________________

____

Restriction of your activities during the past 3 years? ____________________________

Dental exam within the past 6 months? No Yes

Do you wear corrective eyewear? No Yes If Yes: Lenses/Frame Contacts

Do you have a backup pair? Yes No

Allergies? (Medications, foods, vaccines, insects, etc.) Yes Please specify: ______________

Will you be traveling above 8000 feet elevation on land? Yes No

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