UCF | Student Health Services
UNIVERSITY OF CENTRAL FLORIDA

International Health
Travel Clinic

RETURN COMPLETED TO: **medrecords@ucf.edu** prior to your appointment

Travel Clinic Evaluation Patient Worksheet

Name:_____ University ID:_____ Date:_____

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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