

# College of St. Catherine Health and Wellness

## STUDY ABROAD QUESTIONNAIRE

Name: \_\_\_\_\_  
Last First Middle

Today's Date: \_\_\_\_\_

Undergrad  Grad

Date of Birth: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Do you have travel medical insurance?  Yes  No  
If yes, does it include emergency medical evacuation?  Yes  No

Have you had a fever or felt ill in the past 48 hours?  Yes  No

### PAST MEDICAL HISTORY/CURRENT HEALTH PROBLEMS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you being treated for leukemia, lymphoma, cancer, or any other malignant diseases?  Yes  No

Do you have a history of a deficiency of the immune system?  Yes  No

Do you have a history of anemia or any other blood disorder?  Yes  No

Do you have any existing or chronic medical conditions such as heart, liver, kidney, stomach, colon, or lung disease, asthma, allergies or diabetes?  Yes  No

If yes, please list: \_\_\_\_\_

Do you have impaired gastric defenses (such as frequent diarrhea) or use antacids frequently?  Yes  No

Do you have any current or past history of psychiatric disorders (such as depression, panic attacks, psychosis, eating disorder, etc.)?  Yes  No

If yes, please list: \_\_\_\_\_

### CURRENT MEDICATIONS

Are you taking any steroids?  Yes  No

### ALLERGIES (Medications, Vaccinations or Foods)

Have you had allergic reactions to any of the following items? (Please check all that apply)

Eggs  Mercury (thimerosal)  Bee Stings

### FOR WOMEN ONLY

Are you pregnant, suspect you may be pregnant, or trying to become pregnant?  Yes  No

Are you breastfeeding:  Yes  No Date of last menstrual period: \_\_\_\_\_ Urine HCG: +/-

**Date of Departure:** \_\_\_\_\_

**Date of Return:** \_\_\_\_\_

Please indicate the countries you will be visiting in the order in which you will visit them. Also indicate the length of stay in each country.

**Destination**

**Length of Stay**

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What is the purpose of your travel? \_\_\_\_\_

**Please check all that apply to your travel plans:**

- Major resort hotels       Cruise Ships       Camping  
 Staying with a family       Small hotels       Safari  
 Rented foreign home       Youth hostel       Rural travel at any time  
 Residence Hall      Other: \_\_\_\_\_

Are you traveling:       alone       with a group       both

**Please check all the travel vaccines that you have had in the past and list the date of the most recent vaccination if known:**

- Cholera \_\_\_\_\_       Yellow Fever \_\_\_\_\_  
 Hepatitis B \_\_\_\_\_       Tetanus-diphtheria \_\_\_\_\_  
 Rabies \_\_\_\_\_       Tetanus-diphtheria-pertussis (Adacel) \_\_\_\_\_  
 Typhoid-oral or injectable \_\_\_\_\_       Hepatitis A \_\_\_\_\_  
 Polio-oral in injectable \_\_\_\_\_       Influenza \_\_\_\_\_  
 Meningococcal \_\_\_\_\_       Pneumococcal \_\_\_\_\_  
 Malaria drugs \_\_\_\_\_       Measles-mumps-rubella (MMR) \_\_\_\_\_  
 Japanese encephalitis \_\_\_\_\_

**\*\*\* PLEASE SEND IMMUNIZATION RECORDS (OR BRING WITH YOU) TO THE CLINIC FOR YOUR FIRST APPOINTMENT\*\*\***