Swarthmore College Student Health and Wellness Services 500 College Ave, Swarthmore, PA 19081
610-328-8058 health@swarthmore.edu

Travel Health Consult Questionnaire

Name ______________________________ **Date** ______________
DOB __________ **Age** __________ **Cell #** ______________________

Destination(s) and dates of travel ______________________________
____

Prior travel history and dates (location, dates, travel medicine received) ______________
____

Does your health insurance have travel benefits? ______________________

Past Medical History

Allergies/Reactions ______________________________
____

Medications/Herbals/Supplements taken on a daily basis or as needed:
____
____

Past Medical Health History ______________________________
____

Do you wear contact lenses? __________ Do you wear/have glasses? __________

Please note if you have had any of these experiences since freshman year:

Have you received health care at student health or elsewhere?
____
____

Received mental health care ______________________________
ER Visits or Hospitalizations ______________________________
Vaccinations ______________________________
____

Have you volunteered or worked in a healthcare setting, prison, or homeless shelter? __________
Have you had close contact/lived with anyone with tuberculosis? ______________
Have you ever had a positive screening test for tuberculosis? ______________

Have you ever thought you needed to cut down on your drinking or drug use? __________
Have people annoyed you by criticizing your drinking or drug use? __________
Have you ever felt bad or guilty about your drinking or drug use? __________
Have you ever used drinking or drugs to steady your nerves in the morning
to get rid of a hangover? ________

Do you have any Questions or Concerns? ______________________________

Completed and signed by student ______________________ **Date** __________

Reviewed by ______________________________ **Date** ______________

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For office use:
Name of student: ______________________________
Vaccine History reviewed? Yes or No or N/A (notes): ______________
ROS: General ______________________________
HEENT ______________________________
Neck/Nodes ______________________________
Lungs/Chest ______________________________
GI ______________________________
GU ______________________________
Musculoskeletal ______________________________
Neuro ______________________________
Skin ______________________________
Mental/Emotional ______________________________
PHQ-2 Results: ______________________________
Objective: Does student appear alert, well nourished, well developed, in no apparent distress? Y/N
Significant findings in P.E.: ______________________________
Assessment: Travel Health Counseling for the following countries:

____

Other Health Concerns: ______________________________
Plan:
□ **Refer to health care services as needed** ______________________________
□ **Specific Pt. Education/Counseling**

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