Lincoln University

Travel Abroad Health Record

Personal History

Name _____

Address _____

Cell Phone _____ Home Phone _____

Date of Birth _____ Place of Birth _____

Gender ❑ Male ❑ Female

Emergency Contact NAME _____

Emergency Contact Relationship to you _____

Emergency Contact Cell phone _____ Home Phone _____

Emergency Contact Email _____

Social History

Do you consume ALCOHOL? ❑ No ❑ Yes How often? _____

Do you use TOBACCO? ❑ No ❑ Yes How often? _____

Are you currently taking prescription medication? ❑ No ❑ Yes

If YES, list medication(s)_____

Have you ever been treated (medication and/or therapy) for a MENTAL ILLNESS? ❑ No ❑ Yes

If YES, describe condition and treatment _____

_____

Do you have any CHRONIC ILLNESS(s)? ❑ No ❑ Yes

If YES, describe condition(s) and treatment(s) _____

Have you ever experienced:

❑ Diabetes	❑ Tuberculosis	❑ Anxiety/Depression
❑ Hepatitis	❑ Sickle Cell	❑ Epilepsy
❑ Asthma	❑ Stomach/Intestinal Problem	❑ Cancer
❑ Hypertension	❑ Migraine headaches	❑ Leukemia

Have you ever been Hospitalized? ❑ No ❑ Yes

If YES, describe condition _____

Do you have any ALLERGIES (environmental, animal, foods, medications, etc)? ❑ No ❑ Yes

If YES, describe condition and treatment _____

Do you have any DIETARY RESTRICTIONS? ❑ No ❑ Yes

If YES, describe _____

Family History

Do any of your relations have:

❑ High Blood Pressure	❑ Allergies	❑ Diabetes
❑ Heart Disease	❑ Epilepsy	❑ Mental Illness

Student Signature: _____ Date: _____

Health Services Examination

Student Name _____

Weight _____ Height _____

General Appearance _____

Respiratory System: Breath sounds _____ Respiratory rate _____

Cardiovascular System: Pulse _____ /min. B/P _____mmHg

Heart sounds _____

Genito-urinary tract _____

Ear/nose/throat _____

Skin _____

Vision / Hearing _____

Menstruation _____

COMMENTS:

Routine Vaccinations current? ❑ No ❑ Yes

For which county(ies) did you check the CDC website for advice on this student's travel health needs?

_____ _____ _____

Did you recommend any other vaccinations?

❑ Yellow fever ❑ Hep A ❑ Hep B ❑ Tetanus
❑ Typhoid ❑ Polio ❑ Rabies ❑ Malaria
❑ Other _____

Did you administer these recommended vaccinations? ❑ No ❑ Yes

Did you discuss side effects of these vaccinations? ❑ No ❑ Yes

What prescription medications is the student taking now?

What prescriptions do you anticipate the student taking while abroad?

Did you discuss means of medication refills, check to see if legal in Host country? ❑ No ❑ Yes

Doctor's Name _____ Doctor's Signature _____

Qualification _____ Date of Examination _____