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 ______________________________

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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 ______________________