

Pre-Travel Health Assessment Form

Personal Detail	
Name:	Date of Birth (dd/mm/yyyy):
Address: (street, city, postal code)	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Telephone number: _____ Cell: _____
	Email: <input type="checkbox"/> Yes I would like to receive travel updates by email
Weight: _____ pounds, or _____ kg	Family Doctor:
Provincial health care number:	Doctor phone number:

Personal Medical History	
Women: Are you pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you travelling with young children? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been told you have a weakened immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you doing charity work overseas? (refugee camps, missionary work) <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you feeling well today? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or a family member have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your health generally good? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone in your household have a lowered immunity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever fainted or felt unwell after an injection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a history of mental illness such as depression or anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any serious reaction to a vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you suffered from: Jaundice/hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Blood clots <input type="checkbox"/> Yes <input type="checkbox"/> No Ear/hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Any vaccines in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently taking any steroid medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you allergic to eggs, any antibiotics, or latex? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please List all Current Medications (prescription or over-the-counter)	Please List any Allergies: (food or medications)
1.	1.
2.	2.
3.	3.
4.	Please list any other medical conditions
5.	1.
6.	2.
7.	3.

Immunization History	Travel vaccine History - Have you ever received the following immunizations?
Are your regular immunizations up-to-date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
When was the date of your last tetanus shot? (dd/mm/yyyy): <input type="checkbox"/> Not sure	Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you had the:	Rabies <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Annual flu vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Yellow Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Pneumonia vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Japanese encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Chicken pox vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Tick borne encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
MMR vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Typhoid <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
	Oral, Inactivated Cholera and ETEC Diarrhea Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Pre-Travel Health Assessment Form

Trip Details:

Date of departure from Canada (dd/mm/yyyy):

Date of return to Canada (dd/mm/yyyy):

Travel Details:

Country	Town/City	Urban/Rural	Accommodations	Time spent in this country

Rate your Travel Experience

New traveller

Local trips never overseas

Travelled overseas

Experienced traveller

Please provide additional information about your trip:

Reason for Travel

Business

Pleasure

Other:

Holiday Type

Package

Camping

Self-organized

Cruise ship

Backpacking

Trekking

Most common type of accommodation

Premium hotel

Budget hotel

Hostels

Friends/family home

Camping

Who is travelling with you?

Solo

With family/friend

Group

Will any of the following activities be included in your trip plans? (please check all that apply)

Scuba diving

Going to a high altitude

Safari

Spending time in rural communities

Adventure travel

Exposure to extreme heat or cold

Jungle

Other:

Please let us know your primary concerns with your trip or this travel health assessment (check all that apply)

Getting sick while away

Travellers' diarrhea

Safety and efficacy of vaccines

Antimalarial medications

Cost of medications and immunizations

Who to contact if emergency occurs overseas

Travel insurance

Personal safety overseas

Tips to lower your risk of getting sick or hurt overseas

Are there any other concerns that you have that were not discussed on this form? (Please specify)

Please bring this form in when you have your travel consultation and provide it to your travel health pharmacist.