Pre-Travel Health Assessment Form

Personal Detail	
Name:	Date of Birth (dd/mm/yyyy):
Address: (street, city, postal code)	☐ Male ☐ Female
	Telephone number: Cell:
	Email: ☐ 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?	☐ Yes ☐ No	Are you travelling with young children?	☐ Yes ☐ No
Have you been told you have a weakened immune system?	☐ Yes ☐ No	Are you doing charity work overseas? (refugee camps, missionary work)	☐ Yes ☐ No
Are you feeling well today?	☐ Yes ☐ No	Do you or a family member have epilepsy?	☐ Yes ☐ No
Is your health generally good?	☐ Yes ☐ No	Does anyone in your household have a lowered immunity?	☐ Yes ☐ No
Have you ever fainted or felt unwell after an injection?	☐ Yes ☐ No	Do you have a history of mental illness such as depression or anxiety?	☐ Yes ☐ No
Any serious reaction to a vaccine?	☐ Yes ☐ No	Have you suffered from:	
Any vaccines in the last month?	☐ Yes ☐ No	Jaundice/hepatitis	☐ Yes ☐ No
Are you currently taking any steroid medications?	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Are you allergic to eggs, any antibiotics, or latex?	☐ Yes ☐ No	Ear/hearing problems	☐ Yes ☐ No
		Cancer/chemotherapy	☐ Yes ☐ No
		HIV/AIDS	☐ Yes ☐ No
		Diabetes	☐ Yes ☐ No
		Heart disease	☐ Yes ☐ 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?	☐ Yes	☐ No	☐ Not sure	Hepatitis A	☐ Yes	☐ No	☐ Not sure
When was the date of your last tetanus shot?				Hepatitis B	☐ Yes	☐ No	☐ Not sure
Date (dd/mm/yyyy):			☐ Not sure	Rabies	☐ Yes	☐ No	☐ Not sure
Have you had the:				Yellow Fever	☐ Yes	☐ No	☐ Not sure
Annual flu vaccine	☐ Yes	☐ No	☐ Not sure	Japanese encephalitis	☐ Yes	☐ No	☐ Not sure
Pneumonia vaccine	☐ Yes	☐ No	☐ Not sure	Tick borne encephalitis	☐ Yes	☐ No	☐ Not sure
Chicken pox vaccine	☐ Yes	☐ No	☐ Not sure	Typhoid	☐ Yes	☐ No	☐ Not sure
MMR vaccine	☐ Yes	☐ No	☐ Not sure	Oral, Inactivated Cholera and ETEC Diarrhea Vaccine	☐ Yes	☐ No	☐ Not sure
				Meningitis	☐ Yes	☐ No	☐ Not sure

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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.