

Pre-Travel Health Assessment Form

Your personal details			
Name:		Date of birth (dd/mm/yyyy): _____	
Address: (street, city, postal code)		Male _____ Female _____	
		Telephone number: _____	
		Cell number: _____	
		Email: _____	
Weight: _____ pounds, or _____ kg	Provincial health care number: _____	Family doctor: _____ Doctor phone number: _____	

Your 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 health issues such as depression or anxiety?	Yes	No
Any serious reaction to a vaccine?	Yes	No	Have you ever had: Jaundice/hepatitis Blood clots Ear/hearing problems Cancer/chemotherapy HIV/AIDS Diabetes Heart disease	Yes	No
Have you been vaccinated in the last month?	Yes	No		Yes	No
Are you currently taking any steroid medications?	Yes	No		Yes	No
Are you allergic to eggs, any antibiotics, or latex?	Yes	No		Yes	No
				Yes	No

Medications you are currently taking (prescription or over-the-counter)	Allergies (food or medications)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____	1. _____ 2. _____ 3. _____
	Please list any other medical conditions
	1. _____ 2. _____ 3. _____

Your immunization history		Have you ever had 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
		Yellow Fever	Yes	No	Not Sure
Have you had the:		Japanese encephalitis	Yes	No	Not Sure
Annual flu vaccine	Yes No Not Sure	Tick borne encephalitis	Yes	No	Not Sure
Pneumonia vaccine	Yes No Not Sure	Typhoid	Yes	No	Not Sure
Chicken pox vaccine	Yes No Not Sure	Dukoral	Yes	No	Not Sure
MMR vaccine	Yes No Not Sure	Meningitis	Yes	No	Not Sure

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Your trip details

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

Country	Town/City	Urban/Rural	Accommodations	Length of visit

Describe your travel experience

New traveller	Local trips never overseas	Travelled overseas	Experienced traveller
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Additional information about your trip**Reason for travel**

Business	Pleasure	Other: _____
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Holiday type

Package	Camping	Self-organized	Cruise ship	Backpacking	Trekking
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Accommodation

Premium hotel	Budget hotel	Hostels	Friends/family home	Camping
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Who is travelling with you?

Solo	With family/friends	Group
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Do you plan to do any of the following activities? (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: _____
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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 Lowering your risk of getting sick or hurt overseas
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Do you have any other concerns? (Please specify)

Please bring this completed form to your travel health consultation with your Pharmasave pharmacist.

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