

Pre-Travel Health Assessment Form

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

Your 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 health issues 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 ever had: Jaundice/hepatitis Blood clots Ear/hearing problems Cancer/chemotherapy HIV/AIDS Diabetes Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been vaccinated in the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking any steroid medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<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		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Hepatitis A</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Hepatitis B</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Rabies</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Yellow Fever</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Japanese encephalitis</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Tick borne encephalitis</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Typhoid</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Dukoral</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> <tr> <td>Meningitis</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not Sure</td> </tr> </table>	Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	Rabies	<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	Japanese encephalitis	<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	Typhoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	Dukoral	<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
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When was the date of your last tetanus shot? Date (dd/mm/yyyy): _____ <input type="checkbox"/> Not sure																																					
Have you had the:																																					
Annual flu vaccine <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																																					
Chicken pox vaccine <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																																					



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

<input type="checkbox"/> New traveller	<input type="checkbox"/> Local trips never overseas	<input type="checkbox"/> Travelled overseas	<input type="checkbox"/> Experienced traveller
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Additional information about your trip

Reason for travel					
<input type="checkbox"/> Business	<input type="checkbox"/> Pleasure	<input type="checkbox"/> Other: _____			
Holiday type					
<input type="checkbox"/> Package	<input type="checkbox"/> Camping	<input type="checkbox"/> Self-organized	<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Backpacking	<input type="checkbox"/> Trekking
Accommodation					
<input type="checkbox"/> Premium hotel	<input type="checkbox"/> Budget hotel	<input type="checkbox"/> Hostels	<input type="checkbox"/> Friends/family home	<input type="checkbox"/> Camping	
Who is travelling with you?					
<input type="checkbox"/> Solo		<input type="checkbox"/> With family/friends		<input type="checkbox"/> Group	
Do you plan to do any of the following activities? (please check all that apply)					
<input type="checkbox"/> Scuba diving		<input type="checkbox"/> Adventure travel			
<input type="checkbox"/> Going to a high altitude		<input type="checkbox"/> Exposure to extreme heat or cold			
<input type="checkbox"/> Safari		<input type="checkbox"/> Jungle			
<input type="checkbox"/> Spending time in rural communities		<input type="checkbox"/> Other: _____			

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

<input type="checkbox"/> Getting sick while away	<input type="checkbox"/> Who to contact if emergency occurs overseas
<input type="checkbox"/> Travellers' diarrhea	<input type="checkbox"/> Travel insurance
<input type="checkbox"/> Safety and efficacy of vaccines	<input type="checkbox"/> Personal safety overseas
<input type="checkbox"/> Antimalarial medications	<input type="checkbox"/> Lowering your risk of getting sick or hurt overseas
<input type="checkbox"/> Cost of medications and immunizations	

PATIENT CONSENT

- I have read or had explained to me and understand the benefits, side effects and risks of receiving the vaccine(s).
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay in the pharmacy for at least 15 minutes after receiving the vaccine(s).
- I authorize the pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction.
- I release Pharmasave # _____ and the vaccinating pharmacist/healthcare professional _____ from any and all liability.

AND: I consent to receive the vaccine(s) today.

OR: I consent for my child or dependent to receive the vaccine(s) today.

Print Name: _____ Signature: _____ Date: _____

