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:		
Have you been vaccinated 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

Medications you are currently taking (prescription or over-the-counter)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies (food or medications)

1. _____
2. _____
3. _____

Please list any other medical conditions

1. _____
2. _____
3. _____

Your immunization history

Are your regular immunizations up-to-date?
☐ Yes ☐ No ☐ Not sure

When was the date of your last tetanus shot?
Date (dd/mm/yyyy):_____ ☐ Not sure

Have you had the:			
Annual flu vaccine	☐ Yes	☐ No	☐ Not Sure
Pneumonia vaccine	☐ Yes	☐ No	☐ Not Sure
Chicken pox vaccine	☐ Yes	☐ No	☐ Not Sure
MMR vaccine	☐ Yes	☐ No	☐ Not Sure

Have you ever had the following immunizations?

Hepatitis A	☐ Yes	☐ No	☐ Not Sure
Hepatitis B	☐ Yes	☐ No	☐ Not Sure
Rabies	☐ Yes	☐ No	☐ Not Sure
Yellow Fever	☐ Yes	☐ No	☐ Not Sure
Japanese encephalitis	☐ Yes	☐ No	☐ Not Sure
Tick borne encephalitis	☐ Yes	☐ No	☐ Not Sure
Typhoid	☐ Yes	☐ No	☐ Not Sure
Dukoral	☐ 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

Additional information about your trip

Reason for travel

☐ Business ☐ Pleasure ☐ Other:_____

Holiday type

☐ Package ☐ Camping ☐ Self-organized ☐ Cruise ship ☐ Backpacking ☐ Trekking

Accommodation

☐ Premium hotel ☐ Budget hotel ☐ Hostels ☐ Friends/family home ☐ Camping

Who is travelling with you?

☐ Solo ☐ With family/friends ☐ Group

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: _____

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

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 #__024__ 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: _____

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