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
Shingles vaccine	☐ Yes	☐ No	☐ Not Sure
MMR vaccine	☐ Yes	☐ No	☐ Not Sure
COVID-19 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
Polio	☐ 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

Do you have any other concerns? (Please specify)

_____

_____

_____

Please return this completed form to your Pharmasave pharmacist prior to your travel health consultation.

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