Travel Health Program Intake Form

Section 1: Patient Information			Date (MM/DD/YYYY):	
Last Name:	First Name:	Prov. Health Number:	Gender:	Age:
Main Phone Number:	Alternate Phone Number:	Date of Birth (MM/DD/YYYY):	Child's Weight: (kg / lb):	
Address:	City:	Province:	Postal Code:	
Primary Healthcare Provider:	Address:	Contact Number:		

Do you have travel insurance? ☐ Yes ☐ No ☐ Unsure

Does your insurance cover:
Healthcare overseas? ☐ Yes ☐ No ☐ Unsure
Medical evacuation? ☐ Yes ☐ No ☐ Unsure

Section 2: Travel Plans

Date of departure (MM/DD/YYYY):	Date of return (MM/DD/YYYY):
Overall length of trip:	

List of countries to be visited (in order of visit):	Length of stay:
1. ________________	1. ________________
2. ________________	2. ________________
3. ________________	3. ________________
4. ________________	4. ________________

Purpose of trip (check all that apply):
☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit family/friends ☐ Missionary/volunteer/humanitarian relief ☐ Work (urban, office-based, or conference) ☐ Work (rural, outdoors, or in local community) ☐ To obtain medical or dental care ☐ Other:
____

Activities planned (list all):
____

Which of the following area's will you be visiting (check all that apply)? ☐ Urban ☐ Rural ☐ Remote ☐ Unsure

Will you have exposure to animals during your trip? ☐ Yes ☐ No ☐ Unsure
Ascending to high altitudes (2,500 m [8,200 ft] or higher)? ☐ Yes ☐ No ☐ Not sure
Working with potential exposure to body fluids (e.g., medical or dental work)? ☐ Yes ☐ No ☐ Not sure
Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

Accommodations (check all that apply):
☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise ship ☐ Private home (with locals) ☐ Private home (with relatives)
☐ Private home (expatriate or high-end) ☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/hostel
☐ Other: ____________________________

Travel History (List all the countries and year visited in the past 10 years):
____
____

Any questions or concerns about your travel:
____
____
____
____

Section 3: Medical History

Health History (Check all that apply):

Allergies
- ☐ Antibiotics (e.g. penicillin, sulfa, cipro)________
- ☐ Other Medications: __________
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other
- ☐ Side effects/reactions from previous medications (nausea, dizziness, diarrhea, etc.)

Cancer/Blood Disorder
- ☐ Coagulation disorder
- ☐ Cancer history or blood disorder
- ☐ Others:

Cardiovascular
- ☐ Arrythmia (e.g. A.fib, Heart block)
- ☐ implanted pacemaker or automatic defibrillator
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Others:

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Others:

Gastrointestinal
- ☐ Crohn's Disease or Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ GERD
- ☐ Chronic Hepatitis
- ☐ Cirrhosis or Liver Failure
- ☐ Others:

Neurologic/psychiatric
- ☐ Seizures/Epilepsy
- ☐ Anxiety/Depression
- ☐ History of Guillain-Barre Syndrome
- ☐ Others:

Musculoskeletal
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Others:

Immune System
- ☐ Oral steroids in the past 3 months
- ☐ Immune suppressive medications or treatments within the last 3 months (radiation, chemotherapy drugs, methotrexate, azathioprine, adalimumab, etanercept, infliximab, leflunomide, rituximab)
- ☐ No spleen
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
- ☐ Most recent CD4
- ☐ Most recent viral load
- ☐ Organ, bone marrow, stem cell transplant
- ☐ Others:

Kidneys
- ☐ Dialysis
- ☐ Renal insufficiency
- ☐ Others:

Lungs
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Others:

Skin
- ☐ Psoriasis
- ☐ Others:

OB/GYN
- ☐ Pregnant:________weeks
- ☐ Breastfeeding
- ☐ Possible pregnancy in the next 3 months
- ☐ Others:

Vaccination History (Please bring all vaccination records to your appointment):

Vaccine	Yes	No	Unsure
Measles/Mumps/Rubella	☐ Yes When?________________	☐ No	☐ Unsure
Tetanus/Diphtheria/Pertussis	☐ Yes When?________________	☐ No	☐ Unsure
Polio	☐ Yes When?________________	☐ No	☐ Unsure
Herpes Zoster	☐ Yes When?________________	☐ No	☐ Unsure
Varicella	☐ Yes When?________________	☐ No	☐ Unsure
Hepatitis A	☐ Yes When?________________	☐ No	☐ Unsure
Hepatitis B	☐ Yes When?________________	☐ No	☐ Unsure
Meningococcal	☐ Yes When?________________	☐ No	☐ Unsure
Influenza	☐ Yes When?________________	☐ No	☐ Unsure
Pneumococcal	☐ Yes When?________________	☐ No	☐ Unsure
Typhoid	☐ Yes When?________________	☐ No	☐ Unsure
Rabies	☐ Yes When?________________	☐ No	☐ Unsure
Yellow Fever	☐ Yes When?________________	☐ No	☐ Unsure
Japanese Encephalitis	☐ Yes When?________________	☐ No	☐ Unsure
Cholera & ETEC Traveler's Diarrhea	☐ Yes When?________________	☐ No	☐ Unsure

Other: ____

Have you ever had an adverse reaction to a vaccination? ☐ No ☐ Yes - Explain: _________________________

Current Medications (List all current prescription and non-prescription medications. Non-prescription medications include over the counter products, vitamins/supplements, herbals, etc. Include details about how you take it and why you take the medication):	
Medication	**Reason for Use**
Do you have enough supply of medications for the duration of the trip? ☐ Yes ☐ No	

Section 4: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the Travel Health Program at _________________ pharmacy. I have provided all the necessary travel related information. I have had the chance to ask questions, and answers were given to my satisfaction. I understand that some vaccines are publicly funded and may require a visit to the Primary Care Provider or Public Health unit. I understand that I have the freedom to visit pharmacy of my choice for getting the vaccines and medications prescribed to me. I consent that information collected on this form may be shared with my Primary Care Provider. I understand that participating in Travel Health Program does not guarantee that I will not experience any adverse health effects during my Travel.

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)