Pre-Travel Assessment Form

DISPENSARIES

Name:	Provincial Health Services Number:
Address:	Date of Birth: / Weight: ☐ Male ☐ Female ☐ X ☐ Not on Card
Tel: Cell:	Email:
Parent/Guardian (if applicable):	Family doctor or nurse practitioner: Tel: Fax:

Your Medical History

Are you pregnant, considering pregnancy or breastfeeding?	☐ Yes ☐ No
Do you or anyone in your immediate family have a weakened immune system?	☐ Yes ☐ No
Do you have any allergies (medications, vaccines, foods, pollens, etc.)? If yes, please list 1. 2. 3.	☐ Yes ☐ No

Do you have or have you ever had any of the following conditions?

	Yes	No		Yes	No
Jaundice or hepatitis	☐	☐	Blood or clotting disorder	☐	☐
Kidney problems	☐	☐	Heart disease	☐	☐
Ear / hearing problems	☐	☐	Cancer, leukemia	☐	☐
Convulsion, seizures	☐	☐	Mastectomy, lymph node removal	☐	☐
Diabetes	☐	☐	Chronic lung disease (asthma or COPD)	☐	☐
Mental health issues (e.g., anxiety, depression)	☐	☐	HIV/AIDs or other immune system disorder	☐	☐
			Inflammatory bowel disease/digestive disorder	☐	☐

If you have any other health conditions, please list here
1.
2.
3.

Your Medication History

Prescription medications	Over-the counter Medications
1. _____	1.
2. _____	2.
3. _____	3.
4. _____	4.
5. _____	Natural Products (herbal, supplements, etc.)
6. _____	1.
7. _____	2.
8.	3.

Your Immunization History
(Please include a copy or print-out of your immunization records)

Have you received all your routine immunizations?
☐ Yes ☐ No ☐ Not sure – I don't have a record

Date of last flu vaccination: _____ ☐ Not sure ☐ N/A

Date of last COVID-19 vaccination: _____ ☐ Not sure ☐ N/A

When was your last tetanus vaccination? Td or Tdap?
Date: _____ ☐ Not sure

Any vaccines in addition to routine immunizations?
☐ Pneumonia (Pneumococcal P-23)
☐ Pneumonia (Pneumococcal C-13)
☐ Shingles
☐ Haemophilus influenza (Hib)
☐ Pertussis (whooping cough)
☐ Varicella
☐ Other: _____

Have you been vaccinated in the past four (4) weeks? If yes, which?

	Not sure	Yes	# Doses	Date last dose
Hepatitis A	☐	☐		
Hepatitis B	☐	☐		
Hepatitis A + B	☐	☐		
Dukoral®	☐	☐		
Meningococcal C-ACYW	☐	☐		
Meningococcal B4C	☐	☐		
Polio	☐	☐		
Typhoid oral	☐	☐		
Typhoid injection	☐	☐		
Rabies	☐	☐		
Japanese encephalitis	☐	☐		
Tick-borne encephalitis	☐	☐		
Yellow Fever	☐	☐		

Your travel history

☐ New to travel

☐ If previous trips, which Canadian regions or international countries have you visited?	If you became ill or had any health concerns while travelling or after returning, please describe here:

Your trip details

Date of Departure: ____________________________ Date of Return: _________________________

Country	City/Region	Urban/Rural	Accommodations	From:	To:
		☐ Urban ☐ Rural	☐ Premium Hotel ☐ Budget Hotel ☐ Hostel ☐ Family/friends home ☐ Camping		
		☐ Urban ☐ Rural	☐ Premium Hotel ☐ Budget Hotel ☐ Hostel ☐ Family/friends home ☐ Camping		
		☐ Urban ☐ Rural	☐ Premium Hotel ☐ Budget Hotel ☐ Hostel ☐ Family/friends home ☐ Camping		
		☐ Urban ☐ Rural	☐ Premium Hotel ☐ Budget Hotel ☐ Hostel ☐ Family/friends home ☐ Camping		
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		☐ Urban ☐ Rural	☐ Premium Hotel ☐ Budget Hotel ☐ Hostel ☐ Family/friends home ☐ Camping		

Reason for trip: ☐ Pleasure/Holiday ☐ Adoption ☐ Visiting friends and relatives ☐ Missions/humanitarian/volunteer ☐ Study
☐ Business (Type of work): ________________________________ Other: ____

How are you travelling?
☐ Airplane ☐ Cruise ship ☐ Motor vehicle ☐ Other: ______________________________________

Who are you travelling with?
☐ Alone ☐ Spouse/partner ☐ Children ☐ Older adults ☐ Organized group

Do you plan to do any of the following:
☐ Hiking / trekking ☐ Rafting / kayaking ☐ Scuba diving ☐ Caving ☐ Have contact with animals ☐ Spend time in rural areas
☐ Go to a high altitude ☐ Be exposed to extreme heat or cold ☐ Be in a region away from medical help ☐ Safari
☐ Healthcare activities ☐ Wilderness / Extreme sports

What are your primary concerns regarding your health and safety during this trip?

Please fill out and submit this form prior to your appointment with the Travel Health Consultant

Pharmacist name

Contact Information