

Pre-Travel Questionnaire



Please complete this computer fillable questionnaire (best on a laptop or desktop, NOT a tablet or mobile phone), save it to a file, and then return that saved file back by email to globetravelhealth@gmail.com. Hans Epp, your travel health specialist will review the information with you, and may recommend appropriate vaccines and medications which can help you stay healthy and well. globetravelhealth.ca

Personal Information

First Name:	Last Name:
Address:	Postal Code:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Weight:	Height:
Phone:	Email:
Family Physician:	Family Physician Phone:
In what country were you born?	If not in Canada, at what age did you leave your country of birth?
Have you travelled anywhere in the last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes: City, Country:	

Trip Information

Date of Departure:	Duration of the trip: _____ days _____ weeks _____ months
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List all countries and regions (including stopovers) you will visit during your trip:

Country	City / Region	Dates (from – to) (mm/dd/yyyy)
		—
		—
		—
		—

Purpose of Trip (check all that apply):

<input type="checkbox"/> Pleasure / holiday	<input type="checkbox"/> Education/study/summer camp	<input type="checkbox"/> Religious visit	<input type="checkbox"/> Business (specify type of work):
<input type="checkbox"/> Visiting family/friends	<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Adoption	<input type="checkbox"/> Other:

Accommodation (check all that apply):

<input type="checkbox"/> First class hotel or resort	<input type="checkbox"/> Inns / B & B	<input type="checkbox"/> Camps	<input type="checkbox"/> Family/Friends
<input type="checkbox"/> Budget hotels or hostels	<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Company lodge	<input type="checkbox"/> Other:

Activities Planned (check all that apply):

<input type="checkbox"/> Healthcare activities	<input type="checkbox"/> Contact with animals	<input type="checkbox"/> Wilderness activities/ extreme sports	<input type="checkbox"/> Safari
<input type="checkbox"/> Volunteer/Humanitarian activities	<input type="checkbox"/> Veterinary activities	<input type="checkbox"/> Rafting / Water sports	<input type="checkbox"/> Other:
<input type="checkbox"/> Jogging, running, bicycling	<input type="checkbox"/> High altitude activities/ climbing	<input type="checkbox"/> Underwater diving	

Medical History

Have you been vaccinated in the past 4 weeks? No Yes If yes, which vaccine?

Do you have (or have you had) any of the following medical conditions? No Yes:

<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Diabetes (do you require insulin?) Type:	<input type="checkbox"/> Inflammatory bowel disease / digestive disorder
<input type="checkbox"/> Immunosuppression	<input type="checkbox"/> Lung conditions	<input type="checkbox"/> Recent chemotherapy or radiation
<input type="checkbox"/> Heart disease or arrhythmia	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Spleen removed
<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Hay fever/ environmental allergies	<input type="checkbox"/> Organ/Bone marrow transplant
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> History of deep vein thrombosis or clotting disorder	<input type="checkbox"/> G6PD deficiency
<input type="checkbox"/> Thymus disease or thymus removal	<input type="checkbox"/> Headaches Type:	<input type="checkbox"/> Other:

Are you pregnant, planning a pregnancy, or currently breastfeeding? No Yes

Explain:

Are you taking any of the following medications? No Yes:

<input type="checkbox"/> Anticonvulsants	<input type="checkbox"/> Anticoagulant/warfarin	<input type="checkbox"/> Immunosuppressive drugs	<input type="checkbox"/> Antiviral medication (e.g., HIV, other)
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Steroids (e.g., prednisone)	

List current medications (prescription and over-the-counter):

Are you allergic to any of the following? No

<input type="checkbox"/> Eggs Describe reaction:	<input type="checkbox"/> Bee / wasp / insect bites	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Anti-malarial medication Describe reaction:
<input type="checkbox"/> Food: Describe reaction:	<input type="checkbox"/> Thimerosal or aluminum	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Other:
	<input type="checkbox"/> Neomycin, gelatin	<input type="checkbox"/> Sulfa, sulfamycin, Bactrim, Septra	
	<input type="checkbox"/> Formaldehyde or phenol		

Immunization History

I have not had any vaccinations in the past 10 years

Vaccine	Date of Vaccination	Vaccine	Date of Vaccination
<input type="checkbox"/> Td (tetanus/diphtheria)		<input type="checkbox"/> Polio	
<input type="checkbox"/> Tdap		<input type="checkbox"/> Pneumococcal	
<input type="checkbox"/> DTP (diphtheria/tetanus/polio)		<input type="checkbox"/> Rabies	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> TBE vaccine	
<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Yellow fever	
<input type="checkbox"/> Hepatitis A & B combo		<input type="checkbox"/> Zoster (shingles)	
<input type="checkbox"/> Typhoid fever		<input type="checkbox"/> Tick borne encephalitis	
<input type="checkbox"/> Hepatitis A/Typhoid combo		<input type="checkbox"/> Dukoral (cholera & travellers diarrhea)	
<input type="checkbox"/> HPV		<input type="checkbox"/> Varicella (chicken pox)	
<input type="checkbox"/> Influenza		<input type="checkbox"/> Antimalarial medication	
<input type="checkbox"/> Japanese encephalitis		Others: <input type="checkbox"/>	
<input type="checkbox"/> Meningitis		<input type="checkbox"/>	
<input type="checkbox"/> MMR (measles/mumps/rubella)		<input type="checkbox"/>	

Did you have any of the following diseases in your childhood?

Varicella (chicken pox) Mumps Measles Rubella Other:

Have you ever fainted from receiving an injection? No Yes

Have you ever had an adverse reaction to a vaccine? No Yes: Please specify:

To Be Completed By Pharmacist

Based on personal history, travel destinations and activities.

General Comments:

There may be a risk of	Vaccination / Prevention Recommendation
<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Typhoid	
<input type="checkbox"/> Rabies	
<input type="checkbox"/> Measles	
<input type="checkbox"/> Influenza (the flu)	
<input type="checkbox"/> Other	
<input type="checkbox"/> Mosquito-borne Illness	
<input type="checkbox"/> Cholera	
<input type="checkbox"/> Travellers Diarrhea	
<input type="checkbox"/> Other	

Pharmacist Name: _____

Date: _____

