Pre-Travel Questionnaire

Please complete this questionnaire and provide it to your Pharmacist at a Travel Clinic YYC for travel health advice. They will review the information with you, and may recommend the appropriate vaccines and medications which can help you stay healthy.

Personal Information

First Name:	Last Name:
Address:	Postal Code:
Date of Birth:	Gender: ☐ Male ☐ 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? ☐ No ☐ Yes: City, Country:	

Trip Information

Date of Departure: Duration of the trip: _____ days _____ weeks _____ months

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):

☐ Pleasure / holiday ☐ Education/study/summer camp ☐ Religious visit ☐ Business (specify type of work):

☐ Visiting family/friends ☐ Volunteer work ☐ Adoption ☐ Other:

Accommodation (check all that apply):

☐ First class hotel or resort ☐ Inns / B&B ☐ Camps ☐ Family/Friends

☐ Budget hotels or hostels ☐ Cruise ship ☐ Company lodge ☐ Other:

Activities Planned (check all that apply):

☐ Healthcare activities ☐ Contact with animals ☐ Wilderness activities/ extreme sports ☐ Safari

☐ Volunteer/Humanitarian activities ☐ Veterinary activities ☐ Rafting / Water sports ☐ Other:

☐ Jogging, running, bicycling ☐ High altitude activities/ climbing ☐ Underwater diving

Note to Pharmacy: This form to be used only by a Travel Clinic YYC Travel Centre of Excellence

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:

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

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

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

☐ Anticonvulsants	☐ Anticoagulant/warfarin	☐ Immunosuppressive drugs	☐ Antiviral medication (e.g., HIV, other)
☐ Antidepressants	☐ Chemotherapy	☐ Steroids (e.g., prednisone)	

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

Are you allergic to any of the following? ☐ No

☐ Eggs
Describe reaction:

☐ Food:
Describe reaction:

☐ Bee / wasp / insect bites

☐ Thimerosal or aluminum

☐ Neomycin, gelatin

☐ Formaldehyde or phenol

☐ Penicillin

☐ Tetracycline

☐ Sulfa, sulfamycin, Bactrim, Septra

☐ Anti-malarial medication
Describe reaction:

☐ Other:

Immunization History

☐ I have not had any vaccinations in the past 10 years

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

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
☐ Hepatitis A	
☐ Hepatitis B	
☐ Typhoid	
☐ Rabies	
☐ Measles	
☐ Influenza (the flu)	
☐ Other	
☐ Mosquito-borne Illness	
☐ Cholera	
☐ Travellers Diarrhea	
☐ Other	

Pharmacist Name: _____

Date: _____