The Healthy Traveller - Travel Medicine & Vaccination Clinic
Pre-Travel Consultation Form

Thank you in advance for your thoroughness with this process. This is an important first step to guide my research of your travel itinerary. You will then receive the most complete and current information for your trip.
**Please have this form completed a minimum of 1 week before your booked appointment with your Travel Medicine Advisor **

Name: ____
Address: ____
____
Home phone # ____________________ Cell phone # ___________________

Email: ____
Date of Birth: ________________ Health Card # ___________________
Family Physician: __________________________ Dr's Phone # _______________

Allergies to medications, foods or other substances (e.g. pollen, eggs, latex) :

____
____

Medical Conditions (list all past and current conditions):

____
____
____

Medications (list all current prescription, non-prescription, herbal or other):
If you are unsure, you can have your pharmacy provide you with a current medication list from your profile that you can include with this document.

____
____
____
____

Do you drink alcohol?
__ No __ Yes (____ # of drinks/week)

Do you smoke?
__ No __ Yes (____ # of packs/week)

Females: Is there any chance that you are pregnant?

__ No __ Yes

Have you received any of the following vaccinations? If yes, please indicate date. (Please note, if you are unsure, it is your responsibility to check with your family physician, pharmacy and/or Public Health to confirm.)

__ Diphtheria&Tetanus Date: _______
__ Hepatitis A Date: _______
__ Hepatitis B Date: _______
__ Hep. A/B (Twinrix) Date: _______
___Typhoid (oral or injection) Date: _______
__ Measles/Mumps/Rubella Date: _______
__ Polio Date: _______
__ Dukoral (Cholera/E.Coli) Date: _______
__ Other ________________ Date: _______
__ Other ________________ Date: _______

Please list, in order, the countries or areas (be very specific) that you will be visiting during your trip and the duration of your stay in each area:
Departure date: ________________

Destination 1 ________________________________

Length of stay ___________________
Accommodations __________________
Activities planned or potential __________________________________
____

Destination 2 ________________________________

Length of stay _____________________
Accommodations ____________________
Activities planned or potential __________________________________
____

Destination 3 ________________________________

Length of stay _____________________
Accommodations ____________________
Activities planned or potential __________________________________
____

Please include any flight stops and/or layovers (and length of time of layover) here:

Any other important details you would like to share with the Pharmacist/Travel Medicine Advisor?

How did you hear about us?

***Note - once this document is signed and passed in, my research and work begins. If you decide not to come in for your appointment or give 24 hours notice, you will be charged a cancellation fee equal to half the total fee.

Patient signature: ____________________________ Date: ________________

Travel Advisor/
Pharmacist signature : ________________________ Date: ________________