

Date:

Preferred Consult Location:

Pre-Travel Questionnaire: **Please remember to SAVE form before emailing**

Please bring to your appointment: Vaccination records (childhood/travel), travel itinerary and prescription drug coverage. Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your responses. Please return form at least 48 hours prior to appointment.

PERSONAL INFORMATION:

Name:		Date of Birth:	
Address:			
City:	Province:	Postal Code:	
Phone #:	Alberta Healthcare #:		
Email:	Family Doctor:		
Current Weight (lb/kg):	Occupation:		
Country of Birth:	Year of Entry to Canada:		

TRAVEL INFORMATION:

Date of Departure		Date of Return
Emergency Contact:	Name:	
	Phone #:	
	Relationship to you:	

Please list all cities and countries you will visit (including stopovers) during your trip. List areas in order of travel itinerary.

Country	Town/City	Urban/Rural	Accommodations (Type: Resort, Camping, ect.)	Time Spent in Country

Purpose of Trip	<input type="checkbox"/> Pleasure / Holiday <input type="checkbox"/> Visting Family / Friends <input type="checkbox"/> Adoption <input type="checkbox"/> Education / Research <input type="checkbox"/> Volunteer Work <input type="checkbox"/> Business (specify) <input type="checkbox"/> Other
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Activities (check all that apply)

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Rafting/water sports | <input type="checkbox"/> Other |
| <input type="checkbox"/> Contact with Animals | <input type="checkbox"/> High Altitude/climbing | |
| <input type="checkbox"/> Veterinary | <input type="checkbox"/> Wilderness/Extreme Sports | |
| <input type="checkbox"/> Safari | <input type="checkbox"/> Volunteer / Humanitarian | |
| <input type="checkbox"/> Underwater diving | <input type="checkbox"/> Jogging/running/cycling | |

Do you have Travel Health Insurance? Yes No

Travel Experience

- | | |
|--|--|
| <input type="checkbox"/> New Traveller | <input type="checkbox"/> Travelled overseas |
| <input type="checkbox"/> Local trips. Never overseas | <input type="checkbox"/> Experienced Traveller |

MEDICAL INFORMATION:

Do you have (or have you had) any of the following medical conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Auto Immune Disorder
(MS, Rheumatoid Arthritis, Psoriasis, ect.) | <input type="checkbox"/> History of Mental Illness
(anxiety, depression, etc.) | <input type="checkbox"/> Recent chemotherapy / radiation |
| <input type="checkbox"/> Heart disease / Arrhythmia | <input type="checkbox"/> Deep Vein Thrombosis / clotting disorders | <input type="checkbox"/> Organ / Bone marrow transplant |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Spleen removed |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Lung conditions | <input type="checkbox"/> G6PD deficiency |
| <input type="checkbox"/> Thymus disease / removal | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Other |

List Medications (prescription, non-prescription, herbal)

Allergies and other Reactions (describe reaction)

Medications (including Thimerosal, Neomycin, Aluminum)

Food (including eggs)

Vaccines

Insect stings / bites

Environmental

Latex

Needle Anxiety Yes No Fainting Yes No

PERSONAL INFORMATION:

Alberta residents can obtain their Immunization history by calling Alberta Health Link at (403)-943-LINK

Please indicate which of the following vaccines you have had

Date of last Tetanus shot _____

Hepatitis A	Polio
Hepatitis B	Pneumococcal
Hepatitis A&B combo	Rabies
Hepatitis A/Typhoid combo	Influenza
HPV (Gardasil, Cervarix)	Typhoid
Tickborne Encephalitis	Yellow Fever
Japanese encephalitis	Dukoral
Varicella (chicken Pox)	Meningitis
Zostavax (shingles)	MMR

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

Varicella (chicken pox) Mumps
 Measles Other _____

Immunizations:
 Did you receive childhood vaccinations?
 Have you received any vaccines in the past 4 weeks?

For women:
 Are you pregnant? Yes If yes, how many weeks? _____
 No Birth Control? Yes No
 Are you breastfeeding? Yes
 No

How did you hear about us?:

Consult Fees: Single: \$60 Couple: \$110 Family (max 4): \$150
 Please visit www.calgarycoop.com/pharmacy for more details

Patient Signature (to be signed on date of appointment): _____

FOR OFFICE USE ONLY

Date of Consult: _____

Consultant: _____