

Pre-Travel Questionnaire

Please complete this questionnaire, and provide it to your Shoppers Drug Mart Pharmacist for travel health advice. They will review the information with you, and may recommend the appropriate vaccines and medications to help you stay healthy. For family members at same address travelling with you, the following sections only are required: Name, Date of Birth, Medical History and Vaccination status.

Personal Information

First name:	Last name:
Address:	Postal Code:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Phone:	Email:
Family Physician:	Family Physician Phone:

Trip Information

Purpose : <input type="checkbox"/> Vacation <input type="checkbox"/> Other:	
Accommodation: <input type="checkbox"/> Resort <input type="checkbox"/> Cruise <input type="checkbox"/> Family / Friends <input type="checkbox"/> Other:	
Date of Departure:	Length of Stay:

Places To Be Visited

Country	City / Region	Rural Area	Dates (from – to) (mm/dd/yyyy)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	—
		<input type="checkbox"/> Yes <input type="checkbox"/> No	—
		<input type="checkbox"/> Yes <input type="checkbox"/> No	—
		<input type="checkbox"/> Yes <input type="checkbox"/> No	—

Activities Planned

<input type="checkbox"/> Eat at local restaurants / bars	<input type="checkbox"/> Contact with animals	<input type="checkbox"/> Extreme Sports
<input type="checkbox"/> Excursions off Resort	<input type="checkbox"/> Other:	
Do you suffer from motion sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical History

List chronic illnesses:
List of current medications (prescription and over the counter):
List Allergies (eg. Eggs, antibiotics, sulfonamides):
For Women: <input type="checkbox"/> Pregnant <input type="checkbox"/> Planning to become pregnant <input type="checkbox"/> Breastfeeding
History of anxiety or depression: <input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological or Cardiovascular Disorders:

Vaccination History

Are routine immunizations up to date? Yes No Don't know

Explanation:

List other vaccinations received:	Vaccine	Date (mm/dd/yyyy)

Have you had a serious reaction to a vaccine in the past? Yes No

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: _____