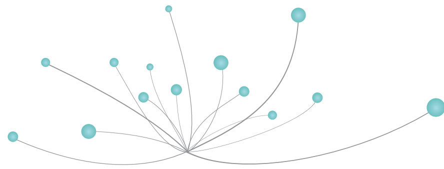

Travel Health Network
VACCINATION CLINIC & CONSULTANTS

Pre-Travel Questionnaire

Please bring **completed questionnaire, travel itinerary** and any **vaccine records** with you to your appointment. We look forward to serving you.

First Name: ____________________

Last Name: ____________________

☐ I have attended the clinic before. There are no changes to my personal information in the box below

Address: ____________________ Date of Birth: __________

____________________ ☐ Male ☐ Female

Postal Code: __________ Home Phone: __________ Cell Phone: __________

Email Address: ____________________

Date of Departure: ____________________

List the countries you are traveling to and for how long: ____________________

____

____

☐ Business ☐ Vacation ☐ Volunteer/Mission ☐ Self-Planned ☐ Tour

Activities planned during travel include:

- ☐ Diving
- ☐ Snorkeling or surfing
- ☐ Travel to rural/remote areas
- ☐ Providing medical care
- ☐ Camping/Trek
- ☐ High Altitude
- ☐ Back-packing/Hostels
- ☐ Restricted work camp

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

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of blood clots
- ☐ Taking blood thinner
- ☐ Heart disease or arrhythmia
- ☐ Seizure disorder
- ☐ Emotional/Psychiatric condition
- ☐ Lung condition
- ☐ Migraines or headaches
- ☐ Diabetes
- ☐ IBS or Digestive tract problems
- ☐ Acid reflux or heartburn
- ☐ Liver or kidney disease
- ☐ Damaged/Removed Spleen or Thymus
- ☐ Recent chemo or radiation (4 mths)
- ☐ Organ or bone marrow transplant
- ☐ Immune suppressed or compromised
- ☐ Psoriasis

Other? ____________________

Are you pregnant, planning to be become pregnant or breastfeeding? ☐ No ☐ Yes

Pre-Travel Questionnaire

Travel Health Network
VACCINATION CLINIC & CONSULTANTS

First Name: ______________________

Last Name: ______________________

Please list or attach a list of your prescription medications and supplements:

____

____

Please tell us about any reactions, allergies or sensitivities you have:

- ☐ Eggs or Chicken
- ☐ Latex
- ☐ Adhesive Bandages
- ☐ Medication ______________________
- ☐ Food or Animal ______________________
- ☐ Seasonal or Environmental ______________________

Weight ______________________

Typical Blood Pressure (if known) ______________________

Do you have (or have you ever) carried an Epi-Pen? ☐ No ☐ Yes (Why?) ______________________

Have you ever had a bad reaction to an anti-malarial medication? ☐ No ☐ Yes (Describe) ______________________

____

Please list any vaccinations that you have received in the past 4 weeks:

____

Please print and bring form. We look forward to seeing you.

Below is For Clinic Use

Consult Fees

	Single	Couple	Family
Standard Consult	$60	$110	$150
Basic Consult - *Mexico, Caribbean, USA and Western Europe*	$45	$80	$100

Family maximum is 4 persons. Each additional family is member $35 / $25. Prices subject to change

**number of vaccines in series*

Vaccine	Price	Vaccine	Price
Hep A/Typhoid	$110	Meningitis A,C,Y,W135	$160
Typhoid Injectable	$60	Tick Borne Encephalitis***	$125
Tetanus/Diphtheria (Td)	$25	Japanese Encephalitis**	$220
Td + Pertussis (Tdap)	$45	Influenza	Free
Tdap + Polio	$110	HPV - Gardasil	$165
Polio	$60	Mantoux	$40
Yellow Fever	***$125***	Rabies***	$220
Typhoid Oral	***$60***	***Shingles***	***$195***
		Measles/Mumps/Rubella*	***$60***

Hepatitis	A**	B ***	A and B***
Adult	$65	$40	$75
Child	$40	$30	$35

Dukoral	Triple	Double	Single
	$130	$95	$50

Florastor	10 cap/$15	50 cap/$45

______________ Reviewed live vaccine risk.

I, ______________________ understand the risks and benefits of vaccination and consent to receiving the vaccines indicated above. I am also aware that it is recommended that I remain in the clinic to be monitored for 15 minutes after vaccination.

Signature: ______________________ Date: ______________________