



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: _____
 _____ Postal Code: _____ Male Female
 Home Phone: _____ Cell Phone: _____ Family Dr. _____
 Email Address: _____ AB Healthcare # _____

Travel Plans? Date of Departure: _____

Country? _____ _____ _____ _____	How Long? _____ _____ _____ _____	<input type="checkbox"/> Vacation	<input type="checkbox"/> Tour
		<input type="checkbox"/> Business	<input type="checkbox"/> Self-Planned
		<input type="checkbox"/> Volunteer/Mission	

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? None

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

Other: _____

Current Medications: _____

Are you pregnant, planning to be become pregnant or breastfeeding? No Yes Not applicable

