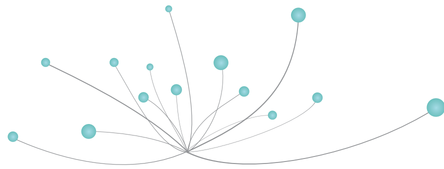

Travel Health Network
VACCINATION CLINIC & CONSULTANTS

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?

☐ Vacation ☐ Tour
☐ Business ☐ Self-Planned
☐ 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**

☐ High blood pressure
☐ High cholesterol
☐ History of blood clots
☐ Taking blood thinner
☐ Heart disease or arrhythmia
☐ Seizure disorder
☐ Emotional/Psychiatric
☐ Lung condition (Asthma/COPD)
☐ 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: ______________________

Current Medications? ______________________

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

Pre-Travel Questionnaire

Travel Health Network
VACCINATION CLINIC & CONSULTANTS

First Name: ______________________

Last Name: ______________________

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

☐ Eggs or Chicken ☐ Latex ☐ Adhesive Bandages

Allergies ______________________

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

Have you ever fainted after an injection? ☐ No ☐ Yes

Do you have a fear of needles? ☐ No ☐ Yes

Weight ______________

Typical Blood Pressure (if known)

____

Have you had any vaccinations in the past 4 weeks? ☐ No ☐ Yes (Which one?) ______________________

How did you hear about our clinic? ______________________

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 x ____. Prices subject to change

***number of vaccines in series**

Vaccine	Price
Hep A/Typhoid	$110
Typhoid Injectable	$70
Tetanus/Diphtheria (Td)	$25
Td + Pertussis (Tdap)	$45
Tdap + Polio	$85
Polio	$85
Pneumococcal 13	$120
Yellow Fever	***$150***
Typhoid Oral	***$70***
Meningitis A,C,Y,W135	$130
Meningitis B **	$145
Japanese Encephalitis**	$220
Influenza	Free
HPV - Gardasil 9***	$190
Mantoux	$50
Rabies***	$220
Pneumococcal 23	$25
Shingles (Shingrix) **	$160
Shingles (Zostavax)	***$205***
Measles/Mumps/Rubella **	***$70***

Hepatitis	A**	B ***	A and B***
Adult	$75	$55	$85
Child	$55	$45	$60

Notes:

______________ 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: ______________