



International Travel Health and Vaccination Clinic Inc.

PLEASE COMPLETE THE CHART UP TO * "FINISH HERE" *****

Last Name: _____ First Name: _____

Address: _____ City _____ Postal Code _____

Date of Birth (M/D/Y): _____ B C Care Card: _____

Home Ph: _____ Secondary Ph: _____

WHERE ARE YOU GOING

Countries to be visited, and duration in each country	Departure Date	Return Date	Office Comments

WHAT ARE YOU DOING ON YOUR TRIP

Purpose of Trip(s)

- Vacation
- Business
- Missionary
- N.G.O. Worker
- Volunteer Relief Worker
- Teacher
- Foreign Student
- Health Worker
- Activity Worker
- High Altitude Trekking
- Trekking
- Scuba Diving
- Cave Exploration
- Other: _____

Type of Travel

- First Class
- Budget Travel
- Cruise
- All Inclusive Resort Hotel
- All Inclusive Tour
- Safari
- Private or Rented Home
- Staying with family or friends
- Camping
- Youth Hostel
- Other: _____

PLEASE FILL OUT THE FOLLOWING MEDICAL HISTORY PAGES

CHARGES

PRICES ARE ALSO ON OUR WEBSITE
WWW.DOCTORTRAVEL.CA

Consultation charges include: risk assessment - documentation - written information - and all follow-up appointments needed to complete your pre travel preparations and vaccinations.

**** Vaccines and other supplies are not included in the service charge.****

Your Travel Consultant will let you know about charges for consultation, vaccines and supplies.

I acknowledge that the above fees are not covered by the Medical Services Plan, and that I am responsible for payment, and I am also aware that the cost of vaccines and supplies are extra.

Signature

Print Name

Fees, and charges for vaccines, and supplies may be covered by your Extended Benefits Plan, and/or may be income tax deductible.

Detailed receipts will be supplied. All medical documentation necessary for your travel will also be supplied.

ABOUT YOUR HEALTH

Immunizations

Yes

No

Office use only

- Do you tend to faint following injections?
- Have you ever had a fever after vaccination?
- Have you ever reacted badly to a vaccine?
- Do you have a problem with your immunity?
- Have you received any blood products or immune globulin in the last 12 months?

DTP, Td
Varicella/live vaccines
Varicella
Varicella, MMR.
Yellow Fever

General Medical

Yes

No

Office use only

- Do you have a medical condition for which you are taking medications or seeing an Doctor?
- Have you had a fever in last 24 to 48 hours?
- Are you possibly pregnant, or plan to be while traveling?
- Do you have a blood or clotting disease or a history of clots in the veins of your legs?

Cholera, DTP, TD, Influenza,
Menningococcol, Pneumococcal
MMR, Oral typhoid, Varicella,
Yellow Fever, Doxycycline,
Lariam, Antibiotics
Traveller's Thrombosis

General Medical	Yes	No	Office use only
- Do you have any stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>	Mefloquine, Doxycycline, Diarrhea
- Do you have any bowel diseases?	<input type="checkbox"/>	<input type="checkbox"/>	TD. Food poisoning
- Have you ever had hepatitis or jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C
- Do you have a history of psychiatric illness?	<input type="checkbox"/>	<input type="checkbox"/>	Lariam
- Do you have a problem with strange dreams and/or nightmares or insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	Lariam
- Do you have frequent yeast vaginitis?	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics (needs antifungal)
- Do you have psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Chloroquine or related compounds
- Have you ever had Malaria?	<input type="checkbox"/>	<input type="checkbox"/>	
- Have you ever had Dengue Fever?	<input type="checkbox"/>	<input type="checkbox"/>	Dengue worse with second attack
- Have you had your spleen removed?	<input type="checkbox"/>	<input type="checkbox"/>	Decreased immunity - needs multiple vaccinations
- Do you have a past history of medical or surgical treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Travel Consultant will get details

YOUR MEDICATIONS

Are you taking:	Yes	No	Office use only
- Quinine, quinidine, or other cardiac medication?	<input type="checkbox"/>	<input type="checkbox"/>	Lariam
- Pepto-bismol - Oral Contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	Doxycycline, Tetracycline
- Aspirin? Anticoagulants?	<input type="checkbox"/>	<input type="checkbox"/>	Varicella
- Antidepressants? Medication(s) for emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	Lariam

Please list all Prescription Medications and Non Prescription Medications:

YOUR ALLERGIES

Please list your drug and non drug allergies

Are you Allergic to:	Yes	No	Office use only
- Penicillin or sulfa?	<input type="checkbox"/>	<input type="checkbox"/>	Diamox, Penicillin, sulfa
- Latex?	<input type="checkbox"/>	<input type="checkbox"/>	
- Mercury or thimerosal?	<input type="checkbox"/>	<input type="checkbox"/>	Influenza
- Stroptomycin - Neomycin - Gentamycin - Polymyxin?	<input type="checkbox"/>	<input type="checkbox"/>	Twinrix- Hep A - IPV - MMR - Rabies - varivax -flu
- Aluminum or aluminum hydroxide?	<input type="checkbox"/>	<input type="checkbox"/>	Twinrix - Td - Rabies - Prevnar
- Bee stings, or have had hives or itchy rash?	<input type="checkbox"/>	<input type="checkbox"/>	Japanese encephalitis
- Yeast?	<input type="checkbox"/>	<input type="checkbox"/>	Hep. B. Twinrix
- Eggs, chicken, or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>	YF, Flu, Rabies, MMR, JBE, Varicella
- Beef Protein, Soy, Casein, Lactose?	<input type="checkbox"/>	<input type="checkbox"/>	IPV, Meningococcal, Oral Typhoid, Rabies, Pneumococcal

I, _____ have completed the medical questionnaire to the best
NAME
of my knowledge and I am aware of all clinic consultation charges and vaccine charges.

SIGNATURE

DATE

***** WE STRONGLY ADVISE YOU TO REMAIN SEATED IN THE CLINIC FOR A MINIMUM OF 20 MINUTES
AFTER VACCINATION *****

**FILL THIS SECTION ONLY IF YOU ARE TO HAVE
YELLOW FEVER VACCINE**

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY,

YES NO

- Are you allergic to eggs, chicken, gelatin or previous Yellow Fever vaccination?
- Are Infants younger than 9 months of age travelling with you?
- Do you have a suppressed immune system?
- Do you have HIV / AIDS?
- Have you had cancer or any cancer treatment including drugs and /or radiation?
- Have you recently taken cortisone medication?
- Have you had Thymus Gland surgery - Myasthenia Gravis - DiGeorge Syndrome or a thymoma?

***** "FINISH HERE" *****

All vaccines including Yellow Fever can have the following adverse reactions:

- Fever - General Fatigue - Soreness / redness or swelling at the site of injection.

Serious Adverse reactions to Yellow Fever Vaccine (this will be explained to you when you come in to the clinic).

- Non life-threatening allergic reaction (approximately 1 per 131,000 doses)
- Yellow fever associated neurotropic disease (YEL-AND) has an incidence of 1:8,000,000 doses.
It has a higher risk in young infants. The recovery rate is close to 100%.
- Life-threatening reactions are extremely rare. Male: Female ratio is 2:1.
- Persons over the age of 60 are more likely to have YEL-AND as well as other severe reactions.

SIGNATURE

DATE

I have had the effects, and possible side effects of Yellow Fever Vaccination explained to me. I am also aware of the above information, and I hereby consent to undergo Yellow Fever Vaccination.

I, _____ have declined the following recommendation:
NAME

- Comprehensive Consultation
- Malaria Chemoprophylaxis
- Prescription
- Vaccines
- Yellow Fever Vaccine

For medical reasons I am unable to take the following

SIGNATURE

DATE