Odyssey Travel & Tropical Medicine Clinic

Locations: Market Mall Professional Centre and Richmond Square Medical Centre

PRE-TRAVEL CLIENT QUESTIONNAIRE FORM

CLIENT INFORMATION:

Name: _____

Email: _____

Employer (if work-related travel): _____

Occupation: _____

Emergency Contact (Name and #): _____

Gender: □ Female □ Male Adults: □ Couple □ Single

Weight (if <18 yrs): _____

Country of Birth: _____ Year of entry into Canada: _____

Places of past residence outside Canada (list all): _____

_____

TRAVEL PLANS (if unsure – include all possible destinations):

Date of Departure: _____ Date of Return: _____

Countries or Regions to visit: Duration:

_____ _____

_____ _____

_____ _____

_____ _____

Will family/friend be doing same trip but different appt time? □ Yes □ No

Name: _____

Accommodation: ☐ Hotel ☐ Home ☐ Dorm ☐ Hostel ☐ Cruise Ship

PURPOSE: (check all that apply):

□ Tourism
□ Visiting Family or Relatives
□ Backpacking or Low-budget
□ Business or Education
□ Volunteering or Missions
□ Military
□ Overseas Adoption
□ Medical treatment or surgery

ACTIVITIES (check all that apply):

□ SCUBA □ Snorkeling
□ Swimming □ High Altitude
□ Raft/Kayak □ Trek/Climbing
□ Jogging □ Safari
□ Camping □ Cycling
□ Animal Handling/Caving
□ Provide health / dental care
□ New sexual partner

Travel History: (List all developing countries visited in past 10 years)

_____

_____

CONSULTANT'S NOTES:

DATE OF VISIT: _____

CONSULTANT: _____

For Office Use Only *Place Label Here* *Revised 2013-10-08*

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CURRENT MEDICATIONS (List all)**:**
(Any prescription, herbal or over-the-counter)

_____
_____

ALLERGIES OR BAD REACTIONS (List all)**:**
☐ Eggs ☐ Latex ☐ Vaccines ☐ Antibiotics ☐ Other:

_____
_____

MALARIA: Have you been on malaria medication? ☐ YES ☐ NO Name and When? _____

MEDICAL HISTORY (Check all that apply to you):

Immunity: ☐Cancer ☐HIV/AIDS ☐Other:
Hormonal: ☐Thyroid ☐Thymus ☐Diabetes ☐Other:
Neurologic: ☐Seizures ☐Migraines ☐Other:
Psychiatric: ☐Depression ☐Anxiety ☐Other:
Head & Neck: ☐Hearing Loss ☐Eye Disease ☐Contacts
☐Sinus/Ear Problems ☐Other:
Respiratory: ☐Asthma ☐Emphysema/COPD ☐Other:
Cardiovascular: ☐Heart Attack ☐Abnormal Rhythm
☐Blood Clots ☐High BP ☐ Bleeding Disorder
☐ Needle Anxiety/Fainting: ☐Other:
Gastrointestinal: ☐Ulcer ☐Heartburn ☐Hepatitis ☐Colitis
☐Irritable Bowel Syndrome ☐Other:
Genitourinary: ☐Bladder Infections ☐Kidney Stones
☐Yeast Vaginitis ☐STDs ☐Other:
Dermatologic: ☐Psoriasis ☐Eczema ☐Body Piercing
☐Tattoos ☐Serious Burns ☐Other:
Musculoskeletal: ☐Arthritis ☐Fractures ☐Gout ☐Other:
Surgery: ☐No Spleen ☐Blood Transfusions ☐Other:

Travel Related Illness: _____

CONSULTANT'S NOTES:

IMMUNIZATION HISTORY: Did you receive all your childhood immunizations? ☐YES ☐NO ☐Not Sure
What province or country did you receive vaccines in? _____
Travel Vaccines? _____
Have you received any vaccines within the past 4 weeks? _____

WOMEN'S HEALTH QUESTIONS: Are you pregnant or trying to get pregnant? ☐ YES ☐ NO

If YES, how many weeks pregnant? _____ WEEKS Are you breastfeeding? ☐ YES ☐ NO

CONSENT TO VACCINATE: I consent to receive the vaccines as desired &/or recommended by the Consultant at Odyssey Travel & Tropical Medicine Clinic.

Send copy of vaccines to family doctor? ☐ Yes Dr: _____

Signature (client/parent/guardian) _____ **Date** _____