

Odyssey Travel & Tropical Medicine Clinics

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: _____

Odyssey Travel & Tropical Medicine Clinic

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):

CONSULTANT'S NOTES:

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: _____

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** _____

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