Pre-Travel Health Questionnaire

River Valley Travel Health

Brought to you by The Medicine Shoppe Pharmacy at the Fredericton Direct Charge Co-op | Guardian Ryan's Pharmacy Nackawic Shopping Centre

Date: _____

Instructions: Please complete this form and bring it to your appointment along with all immunization records.

PART A: Patient Demographics

Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Home Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

Weight: _____ Height: _____ Family Physician: _____

Primary Insurance Provider: _____ Medicare Number: _____

Does your insurance cover:

Healthcare overseas? ☐ Yes ☐ No ☐ Unsure

Medical evacuation? ☐ Yes ☐ No ☐ Unsure

PART B: Health History (please check all that apply)

Allergies

- ☐ Antibiotics (ex. penicillin, sulfa) _____
- ☐ Latex
- ☐ Bees/Wasps
- ☐ Egg
- ☐ Other food _____
- ☐ Other medication _____
- ☐ Gelatin
- ☐ Seasonal
- ☐ Yeast
- ☐ Other _____

Current or Past Medical Conditions

- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Liver Disease (hepatitis, etc.)
- ☐ Stomach (IBS, IBD, Celiac, etc.)
- ☐ Ulcers (Stomach, etc.)
- ☐ Thyroid Disease
- ☐ Hormonal Issues
- ☐ Lung Condition (asthma, COPD, etc.)
- ☐ Epilepsy or Seizures
- ☐ Kidney disease
- ☐ Skin Problems (Psoriasis, etc.)
- ☐ Blood Clotting Problems
- ☐ Diabetes
- ☐ Arthritis or Joint Problems
- ☐ Headaches/Migraines
- ☐ Eye Disease (Glaucoma, etc.)
- ☐ Immune System Disorder (HIV, etc.)
- ☐ Other:_____

Pre-Travel Health Questionnaire

River Valley Travel Health

Brought to you by The Medicine Shoppe Pharmacy at the Fredericton Direct Charge Co-op | Guardian Ryan's Pharmacy Nackawic Shopping Centre

Please answer the following questions

Are you currently pregnant? ☐ Yes ☐ No _____ weeks

Are you currently breastfeeding? ☐ Yes ☐ No

Are you planning to become pregnant during your trip or within the next 3 months? ☐ Yes ☐ No

Have you ever fainted after receiving a vaccine or giving blood? ☐ Yes ☐ No

Do you carry an Epipen? ☐ Yes ☐ No

Current Prescription Medications: Please list all prescription meds including creams, patches, injections, eye drops, and inhalers.

Medication	Dosage	How often?

Vitamins/Natural Supplements: Please list all vitamins, minerals, herbs, enzymes, supplements, and probiotics

Vitamin/Supplement	Dosage	How often?

Pre-Travel Health Questionnaire

River Valley Travel Health

Brought to you by The Medicine Shoppe Pharmacy at the Fredericton Direct Charge Co-op | Guardian Ryan's Pharmacy Nackawic Shopping Centre

PART C: Travel Plans

Country and City	Arrival Date	Departure Date

Purpose of trip

(check all that apply)

- ☐ Vacation
- ☐ Missionary/Volunteer/Humanitarian Relief
- ☐ Work (rural, outdoors, or in local community)
- ☐ Education
- ☐ Other:
- ☐ Work (urban, office-based, or conference)
- ☐ To obtain medical or dental care
- ☐ Visiting friends/family

Planned activities (list all): _____

Will you be:

Traveling:

- ☐ Alone
- ☐ With a spouse
- ☐ With a group

Visiting areas that are:

Rural	☐ Yes	☐ No	☐ Unsure
Urban	☐ Yes	☐ No	☐ Unsure
Remote	☐ Yes	☐ No	☐ Unsure

Ascending to high altitudes (8,000 ft or higher)?	☐ Yes	☐ No	☐ Unsure
Potentially exposed to body fluids (ex. medical or dental work)?	☐ Yes	☐ No	☐ Unsure
Exposed to animals?	☐ Yes	☐ No	☐ Unsure
Potentially having new sexual partners?	☐ Yes	☐ No	☐ Unsure

Accommodations

(check all that apply)

- ☐ Resort/Large Hotel
- ☐ Private home (with relatives)
- ☐ Small hotel/B&B
- ☐ Camping
- ☐ Other:
- ☐ Cruise Ship
- ☐ Up-scale camp/lodge
- ☐ Private home (with locals)
- ☐ Dormitory/Hostel

Pre-Travel Health Questionnaire

River Valley Travel Health

Brought to you by The Medicine Shoppe Pharmacy at the Fredericton Direct Charge Co-op | Guardian Ryan's Pharmacy Nackawic Shopping Centre

PART D: Immunization History

Have you ever experienced an adverse effect or allergic reaction to a vaccine? ☐ Yes ☐ No ☐ Unsure

Are your childhood vaccines up to date? ☐ Yes ☐ No ☐ Unsure

Have you ever received the following vaccines?

Vaccine	Received Before? (Yes / No / Unknown)	When? (Approximate Date)
Hepatitis A		
Hepatitis B		
Typhoid (Oral or Injectable)		
Polio (Oral or Injectable)		
Meningitis		
Measles-Mumps-Rubella (MMR)		
Tetanus		
Pneumococcal		
Yellow Fever		
Dukoral		
Influenza		
Other:		

Have you received medication to prevent malaria in the past? ☐ Yes ☐ No ☐ Unsure

If yes, which one: _____

Part E: Questions or Concerns

Please list all questions or concerns you have regarding your upcoming trip.