Pre-Travel Questionnaire

Please complete this questionnaire, and provide it to your Pharmacist for travel health advice.
They will review the information with you, and may recommend the appropriate vaccines and medications to help you stay healthy. For family members at same address travelling with you, the following sections only are required: Name, Date of Birth, Medical History and Vaccination status.

Personal Information

First name:	Last name:
Address:	Postal Code:
Date of Birth:	Gender: ☐ Male ☐ Female
Phone:	Email:
Family Physician:	Family Physician Phone:

Trip Information

Purpose : ☐ Vacation ☐ Other:

Accommodation: ☐ Resort ☐ Cruise ☐ Family / Friends ☐ Other:

Date of Departure: Length of Stay:

Places To Be Visited

Country	City / Region	Rural Area	Dates (from – to) (mm/dd/yyyy)
		☐ Yes ☐ No	—
		☐ Yes ☐ No	—
		☐ Yes ☐ No	—
		☐ Yes ☐ No	—

Activities Planned

☐ Eat at local restaurants / bars ☐ Contact with animals ☐ Extreme Sports

☐ Excursions off Resort ☐ Other:

Do you suffer from motion sickness? ☐ Yes ☐ No

Medical History

List chronic illnesses:

List of current medications
(prescription and over the counter):

List Allergies
(eg. Eggs, antibiotics, sulfonamides):

For Women: ☐ Pregnant ☐ Planning to become pregnant ☐ Breastfeeding

History of anxiety or depression: ☐ Yes ☐ No

Neurological or Cardiovascular Disorders:

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Vaccination History

Are routine immunizations up to date? ☐ Yes ☐ No ☐ Don't know

Explanation:

List other vaccinations received:	**Vaccine**	**Date (mm/dd/yyyy)**

Have you had a serious reaction to a vaccine in the past? ☐ Yes ☐ No

To Be Completed By Pharmacist

Based on personal history, travel destinations and activities.

General Comments

There may be a risk of	**Vaccination / Prevention Recommendation**
☐ Hepatitis A ☐ Hepatitis B ☐ Typhoid ☐ Rabies ☐ Measles ☐ Influenza (the flu) ☐ Other	
☐ Mosquito-borne Illness ☐ Cholera ☐ Travellers Diarrhea ☐ Other	

Pharmacist Name: _____

Date: _____

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