Guardian **Townline Guardian Pharmacy** | 10A - 1414 King St E in Courtice, ON | Tel: 905-721-8828

Pre-Travel Health Assessment Form

Full Name:	**Age**:	**Birthday** *(dd/mm/yyyy)*:
Address: (street, city, postal code)	☐ Female ☐ Male ☐ Breastfeeding ☐ Pregnant, which trimester?	
	Phone Number:	
	Email address:	
Weight (children): ____ lbs or ____ kg ☐ I have Private Insurance	Family Doctor Name: Doctor Office Phone #:	

Immunization History

Have you ever received any vaccines for the following? (please provide as much information as you can)

Is your *routine immunization* up-to-date? ☐Yes ☐No ☐Not Sure		**Traveler's Diarrhea** (Dukoral oral vaccine)	☐ Yes, date *(mm/yy)*:
Tetanus/Diphtheria/ Pertussis	☐ Yes, date of last dose: ☐ Not sure	**Hepatitis A** (Avaxim, Havrix, Vaqta)	☐ Yes, date *(mm/yy)*: Vaccine name:
		Hepatitis B (Engerix, Recombivax HB)	☐ Yes, date *(mm/yy)*: Vaccine name:
Polio	☐ Yes ☐ Not sure	**Hepatitis A & B Combined** (Twinrix)	☐ Yes, date *(mm/yy)*:
H. influenzae type b	☐ Yes ☐ Not sure	**Hepatitis A & Typhoid Combined** (ViVAXIM)	☐ Yes, date *(mm/yy)*:
Yearly Flu Shot	☐ Yes ☐ Not sure	**Japanese Encephalitis** (Ixiaro)	☐ Yes, date *(mm/yy)*:
Human papillomavirus (HPV)	☐ Yes ☐ Not sure	**Meningococcal** (Menveo, Menactra, Nimenrix, Bexsero, Trumenba)	☐ Yes, date *(mm/yy)*: Vaccine name:
Chickenpox	☐ Yes ☐ Not sure	**Pneumococcal** (Prevnar 13, Pneumovax 23)	☐ Yes, date *(mm/yy)*: Vaccine name:
Measles / Mumps / Rubella	☐ Yes ☐ Not sure	**Rabies** (IMOVAX-Rabies, RabAvert)	☐ Yes, date *(mm/yy)*: Vaccine name:
Comments:		**Shingles** (Zostavax, Shingrix)	☐ Yes, date *(mm/yy)*: Vaccine name:
		Typhoid (Vivotif oral vaccine, Typhim Vi)	☐ Yes, date *(mm/yy)*: Vaccine name:
		Yellow Fever (YF-Vax)	☐ Yes, date *(mm/yy)*:

Personal Medical History (please select everything that applies)	**Current Medical Condition**	
☐ I have a weakened immune system due to my medical conditions or medications.	☐ Mental health conditions	☐ Kidney disease
☐ I am currently taking corticosteroid medication (ie. prednisone).	☐ Thymus disease	☐ Liver disease or hepatitis
☐ Someone else in my household has a weakened immune system.	☐ No spleen	☐ Ear/hearing problems
☐ I recently had surgery.	☐ Blood clots	☐ Cancer/Chemotherapy
☐ I have a history of *Guillain-Barre syndrome*.	☐ Bleeding disorder	☐ HIV
☐ I am living with disability.	☐ Seizure	☐ Heart disease
☐ My health is generally good.	☐ Diabetes	☐ Lung disease
☐ I have had serious reactions to a vaccine before (ie. anaphylaxis).	☐ Gastrointestinal disorders	☐ Stroke
☐ I was vaccinated *last* month. The vaccine name was:	☐ Psoriasis	☐ Myasthenia gravis

Please list all **current medications**, including prescription and non-prescription medications.	What is the medication used for?	Please list all **allergies**, including to vaccines, food, latex, chemicals, medications.
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.
6.		6.
7.		7.
8.		8.
9.		9.
10.		10.
11.		11.
12.		12.

PLEASE PROVIDE INFORMATION ABOUT YOUR TRIP (please select all applicable categories)		
What is your travel experience?	☐ New traveler ☐ Local trips never overseas ☐ Travelled overseas ☐ Experienced traveler	
Please elaborate on whether you have experienced any *travel-related illnesses* in the past, as well as your previous experience with *preventative medications* for malaria, traveler's diarrhea, or altitude sickness, if applicable.		
Why are you travelling this time?	☐ Business ☐ Pleasure ☐ Other:	
What kind of travel?	☐ Independent travel ☐ Package tour ☐ Camping ☐ Cruise ship ☐ Backpacking ☐ Trekking	
Where will you be staying at?	☐ Premium hotel ☐ Budget hotel ☐ Hostels ☐ Family/friends home ☐ Camping	
Who is travelling with you?	☐ Solo ☐ Hostels ☐ With family/friends ☐ Group	
Are you travelling with young children?	☐ Yes ☐ No	
Are you doing charity work overseas? (refugee camps, missionary work)	☐ Yes ☐ No	
Are you planning to do any of these activities during your trip?	☐ Scuba diving	☐ Adventure travel
	☐ Rafting or other water exposure	☐ Exposure to extreme heat or cold
	☐ Safari or any anticipated interaction with animals	☐ Jungle
	☐ Spending time in rural communities	☐ Disaster relief
	☐ Going to a high altitude	☐ Provide or receive medical care

Date of Departure from Canada *(dd/mm/yyyy):*	**Date of Return to Canada** *(dd/mm/yyyy):*

Travel Destinations (please list in the order of entry)

Country	**Town/City**	**Urban/Rural**	**Accommodation Type** (ie. premium hotels, budget hotels, hostels, camping, friend's home, etc)	**Time** spent in this country (days)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please let us know if you have any other additional questions or concerns.

Please fill out the form for each traveler, and then email the completed form to vaccine@townlinepharmacy.ca as soon as possible so that we can prepare for your appointment and plan your immunization schedule.