Travel Clinic

Please complete this form and submit it at least 24 hours prior to your scheduled appointment.
This form may be submitted in person to the reception desk or emailed to travel@carolinefht.ca
Please remember to bring your immunization record to the appointment.

Date: _____MM/DD/YYYY_____

Contact Information:

Last Name: _____ First name: _____

Street: _____

City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____

Medical Information:

Do you have any of the following allergies?

☐ No known drug allergies

☐ Egg ☐ Sulfa drugs ☐ Penicillin ☐ Ciprofloxacin

☐ Doxycycline ☐ Azithromycin ☐ Malarone

☐ Other: Please specify: _____

For women only:

Are you pregnant? ☐ No ☐ Yes _____weeks ☐ Planning within 3 months

Are you breastfeeding? ☐ No ☐ Yes

Caroline Family Health Team

Travel Clinic

Do you have any of the following medical conditions?

☐ No medical conditions

☐ Seizures ☐ Diabetes ☐ Depression ☐ Anxiety

☐ G6PD deficiency ☐ Heart disease ☐Thymus disease ☐ Asthma

☐ Immunodeficiency (ie. HIV, cancer, transplant) specify: _____

☐ Inflammatory bowel disease ☐ Blood disorders (coagulation disorders) ☐ Other: _____

Have you had any of the following immunizations?

Hepatitis A	☐No	☐Not sure	☐Yes Date: _____
Hepatitis B	☐No	☐Not sure	☐Yes Date: _____
Typhoid	☐No	☐Not sure	☐Yes Date: _____
Yellow Fever	☐No	☐Not sure	☐Yes Date: _____
Japanese Encephalitis	☐No	☐Not sure	☐Yes Date: _____
Dukoral (Traveler's Diarrhea)	☐No	☐Not sure	☐Yes Date: _____
Meningococcal	☐No	☐Not sure	☐Yes Date: _____
Tetanus	☐No	☐Not sure	☐Yes Date: _____
Rabies	☐No	☐Not sure	☐Yes Date: _____

Do you take any medications (including prescription, over the counter and herbals/supplements)?

☐ No medications

☐ I take the following: _____ _____

_____ _____

_____ _____

3305 Harvester Road Units 15-20 Burlington ON L7N 3N2 Phone:(905) 632-8007 Fax:(905) 632-6703
www.carolinefht.ca

Caroline Family Health Team

Travel Clinic

Departure date: MM/DD/YYYY Return date: MM/DD/YYYY Duration of trip: _____

Purpose of trip: _____

	Countries to be visited	City or town	Duration
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

During this trip, do you plan to:

Go outside the city centres at anytime?	☐No	☐Maybe	☐Yes
Stay outside of hotels?	☐No	☐Maybe	☐Yes
Go camping?	☐No	☐Maybe	☐Yes
Go hiking?	☐No	☐Maybe	☐Yes
Go into caves?	☐No	☐Maybe	☐Yes
Visit friends or family?	☐No	☐Maybe	☐Yes
Ascend to high altitudes (2300+ meters or 7000+ feet)	☐No	☐Maybe	☐Yes
Work with animals?	☐No	☐Maybe	☐Yes
Have potential sexual contact with new partners?	☐No	☐Maybe	☐Yes
Possibly receive a manicure, pedicure or tattoo?	☐No	☐Maybe	☐Yes

Do you have any other travel related concerns?

_____

☐ All of the information on this form is accurate to the best of my knowledge and I understand that any false information could negatively impact my health.

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