TravelMed Vaccine Centre

600 Sherbourne St, Toronto, ON M4X 1W4,
TEL: (416) 346-4535. FAX: 416-927-0709

You MUST remain in the clinic for 15 minutes following vaccination(s).

PATIENT INFORMATION (To be completed by the traveller) Date: ___ / ___ /_____ (DD/MM/YYYY)

Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your responses.

Gender: Male ☐ Female ☐ Age:_____ Date of birth: ____ / ____ /_____ (DD/MM/YYYY)

Last name: _____ First name: _____

Street: _____City: _____ Province: _____

Country: _____ Postal code: _____

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

E-mail: _____@_____Weight (if under 18 yrs): _____☐ lbs ☐ kg

In what country were you born? _____If not in Canada, at what age did you come to Canada? ____

Job title:_____

Emergency contact: _____ Phone: _____

Your Family Doctor: Last Name:_____ First Name:_____

MEDICAL INFORMATION

Please rate your overall health? (Check only one) Poor ☐ Fair ☐ Good ☐ Excellent ☐ AGE:

Allergies: Eggs: Yes ☐ No ☐ *Wasp/Bees: Yes ☐ No ☐ *Latex: Yes ☐ No ☐ *Neomycin: Yes ☐ No ☐ *Gelatine Yes ☐ No ☐ *Seasonal Allerg: Yes ☐ No ☐

Have you ever had the Hepatitis disease?	Yes ☐ No ☐	If Yes, what type? A ☐ B ☐ C ☐
Are you allergic to or have any bad reaction to any drugs, foods or vaccines?	Yes ☐ No ☐	If Yes, please specify:
Have you fainted or felt dizzy after vaccination in the past?	Yes ☐ No ☐	
Are you on any blood thinners, Prednisone, immunosuppressive or anti-cancer drugs?	Yes ☐ No ☐	If Yes, please specify:
Have you been sick on any past trips?	Yes ☐ No ☐	If Yes, what happened?

Check () appropriate boxes, if you suffer from or have experienced any of the following conditions?

☐ Heart disease	☐ Lung disease	☐ Asthma	☐ Ulcers	☐ Dizziness	☐ Sun allergy
☐ Deafness	☐ Diabetes	☐ Insomnia	☐ Kidney disease	☐ High blood pressure	☐ Low Blood Pressure
☐ Ear Perforations	☐ Depression	☐ Crohn's	☐ Ulcerative colitis	☐ AIDS/HIV	☐ Sun Stroke
☐ Hepatitis A, B , C	☐ Fear of flying	☐ Cancer	☐ Splenectomy	☐ Immunodeficiency	☐ Recurrent Pneumonia
☐ Motion sickness	☐ Mental illness	☐ Psoriasis	☐ Currently have a fever	☐ Mountain sickness	☐ Fear of Needles
☐ Seizures/Epilepsy	☐ Chicken Pox	☐ Stroke	☐ Jetlag	☐ Traveler's thrombosis	☐ Other:

CURRENT MEDICATION(S):

Have you taken any of the following for malaria prevention? If yes, check the () appropriate boxes and state if you experienced any side effects:
Mefloquine ☐ Malarone ☐ Doxy ☐ Chloroquine ☐ Other: _____

THE SECTION INSIDE THIS BOX IS FOR FEMALES ONLY

Are you pregnant?	Yes ☐ No ☐	Are you trying to get pregnant?	Yes ☐ No ☐
Are you/will you be breast feeding?	Yes ☐ No ☐	Have you ever had an abnormal Pap Test result?	Yes ☐ No ☐

FOR OFFICE USE

AS PER MEDICAL DIRECTIVE BY DR. VELIZAR HARIZANOV

Primary check: Dr. Harizanov ☐ Dr. Angelov ☐ Secondary check: Dr. Harizanov ☐ Dr. Angelov ☐

REPORT FAXED: Y___N___ SCAN: Y___ DATE: _____ PREPAID FOR VACCINE: YES ☐ NO ☐ AMOUNT:

ITINERARY Departure date: _____ / _____ /_____ (DD/MM/YYYY) **Duration of trip: _____**

Please, list all countries and regions you will visit (including stop over) during your trip		
NAME OF COUNTRY	AREA OR CITY	LENGTH OF YOUR STAY

Purpose of your trip:	Business ☐	Pleasure ☐	Both ☐

Do you anticipate being exposed to any of these risks on your trip?				
☐ Extreme heat	☐ Physical exertion	☐ Swimming	☐ Poor water	☐ Poor sanitation
☐ Extreme cold	☐ High stress	☐ Diving	☐ Motorcycles	☐ Poor diet
☐ Extreme stress	☐ High altitude	☐ Trekking or Climbing	☐ Risk of sexually transmitted disease	

Please specify the type(s) of trip you are engaging in?		
☐ Staying with family/Relatives	☐ Missionary or voluntary work	☐ Developmental work
☐ Affluent Travel in a quality hotel	☐ Travel in rural or remote areas	
☐ Business travel in an urban area	☐ Backpacking or trekking in mountains/jungles	

VACCINATION RECORD HISTORY Were you fully vaccinated as a child? YES ☐ NO ☐

Have you had the following routine immunization/vaccines in the last 10 years? Check the () appropriate boxes.

Prior immunizations:	yes	no	don't know	approx. date
Tetanus-Diphtheria	☐	☐	☐	
Polio	☐	☐	☐	
Act – HIB	☐	☐	☐	
Chicken Pox	☐	☐	☐	DOSE: #1: #2:
Rotatex/Rotarix	☐	☐	☐	
B.C.G (T.B.)	☐	☐	☐	
Measles, Mumps, Rubella	☐	☐	☐	DOSE: #1: #2:
Bexsero	☐	☐	☐	DOSE: #1: #2: #3:
Influenza vaccine (flu shot)	☐	☐	☐	
Gardasil	☐	☐	☐	DOSE: #1: #2: #3:
Dukoral	☐	☐	☐	
Hepatitis A vacc.	☐	☐	☐	DOSE: #1: #2:
Hepatitis B vacc.	☐	☐	☐	DOSE: #1: #2: #3:
Twinrix	☐	☐	☐	DOSE: #1: #2: #3:
Meningococcal	☐	☐	☐	
Injectable Typhoid	☐	☐	☐	
Oral Typhoid	☐	☐	☐	
Japanese Encephalitis	☐	☐	☐	DOSE: #1: #2
Pneumonia vaccine Pn 23 ☐ Pr 13 ☐	☐	☐	☐	
Rabies vaccine	☐	☐	☐	DOSE: #1: #2: #3:
Tick Borne Encephalitis	☐	☐	☐	
Yellow Fever	☐	☐	☐	
Zostavax (Shingles)	☐	☐	☐	

PLEASE READ AND SIGN

I understand that this visit and the vaccinations are not covered by OHIP. Our consultation fee is $25.00 if your appointment is on Wednesdays and $35.00 for all other days. The follow up fee for booster shots is $20.00 plus the cost of the vaccines. All prices are subject to change without notice. We accept visa and mastercard credit cards and interac.

I agree to stay seated in the waiting room for observation for 15 minutes after vaccination of all vaccines, with the exception of the yellow fever vaccine for which I will remain seated in the waiting room for 30 minutes after vaccination. I declare that all information provided on this form is accurate to the best of my knowledge and that any inaccurate information maybe detrimental. I consent to be treated by any of the following people: Canadian or International Medical Graduate.

SIGNATURE OF PATIENT OR GUARDIAN:	DATE: