# TravelMed Vaccine Centre

600 Sherbourne St, Toronto, ON M4X 1W4, TEL:416 346 4535

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 Allergy: 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. Karagiozov

Primary check: Dr Karagiozov Dr. Kavian Secondary check: Dr Karagiozov Dr.Kavian

**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 below.

| **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: |
| 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. For our consultation fees please visit our website *Travelmed.ca*
All prices are subject to change without notice.
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:** |
|---|---|
| | |