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 Parham Kavian/IMG Secondary check: Dr Karagiozov Parham Kavian/IMG

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:**