

Westend FamilyCare Clinic FHT
Travel Medicine Intake Form

Please fill this form prior to your appointment
Please bring your immunization record
Have this form and your immunization record in hand at your appointment
Please note that all family members must be present at the same appointment
for discounted consultation rates.

Name _____ Date of birth _____

Medical History:

Current Medications:

Allergies to medication and type of reaction:

Are you allergic to eggs or latex?

Are you pregnant? Y/N How many weeks? Now: At the time of travel:

Are you planning to get pregnant? Y/N

Are you breastfeeding? Y/N

When are you leaving?

How long will you stay at your destination(s)?

Where are you going? List all destinations.

Reason for visit: Leisure, business, other

What kind of accommodations?

What activities are planned on your trip?

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Have you had a complete series of childhood immunizations? Y/N

Have you ever had an allergic reaction to a vaccine? Y/N

If yes, which vaccine and what type of reaction did you have?

Have you taken malaria medications before? Y/N

Did you have an adverse reaction? Y/N. Please give details.

Will you be hiking or driving above an altitude of 9000 ft/2750m? Y/N. How high?

Have you ever had altitude illness? Y/N

Have you ever taken medications to prevent altitude illness? Y/N

Did you have an adverse reaction? Y/N. Please give details.

Will you be in contact with animals? Y/N

Have you ever had dengue fever? Y/N

I acknowledge that Dr Charland/Dr Copley is only seeing me for travel medicine.

Other medical concerns or questions should be directed to your primary care physician at a regular appointment.

Signature: _____

Date: _____

Please be aware that after a vaccination you will need to wait in the waiting room for 15 minutes prior to leaving.