Date of appointment: Date of client's 1st contact:

Travel Health Clinic

<table>
<tr>
<td>All international travelers should complete the following questionnaire 8-12 weeks prior to initial visit to Travel Health Clinic. Certain information is necessary for proper treatment and recommendations prior to your trip. Please complete the following as best as you can. All information is considered confidential.</td>
<td>NAME: ____________________________

DOB: ____________ Ph #____________</td>
</tr>
</table>

THE PERSONAL HEALTH INFORMATION ON THIS FORM IS COLLECTED UNDER THE NWT HEALTH INFORMATION ACT AND WILL NOT BE USED OR DISCLOSED UNLESS ALLOWED OR REQUIRED BY THIS ACT OR ANY OTHER ACT.

( ) Fees have been reviewed Initial and Date___________________

Travel Plans:

Date Leaving Yellowknife: _____________ Date Leaving Canada: ____________ Length of trip: _______________

Purpose of trip: [ ] business, [ ] pleasure, [ ] other ____________

Type of travel: [ ] urban (cities, towns), [ ] rural (villages, countryside)

Type of Accommodation: [ ] hotel, [ ] resort, [ ] hostels, [ ] camping, [ ] cruise ship, [ ] staying with relatives/friends.

Types of Activity: [ ] hiking, [ ] mountain climbing, [ ] scuba diving, [ ] cave diving, [ ] eco-traveler, [ ] other _________

Please list all countries in order of visit and the expected time of stay in each country:

	Country	City	Length of Stay
1.			
2.			
3.			
4.			
5.			
6.			

Please identify any special concerns you have about this trip:

Health History: Date________________

Do you have any **allergies**?

Yes No Please list:

____

Are you currently taking medications?

Yes No Please list all medications including birth control, herbal preparations and OTC medications:

____

Do you have any special health concerns? Please identify. ________________________________

Yes No Have you ever had a serious reaction to an immunization?
Yes No Have you ever had seizures or neurological conditions?
Yes No Do you have diabetes?
Yes No Have you ever had heart disease/surgery?
Yes No Have you ever had any lung disease?
Yes No Have you ever had any liver disease?
Yes No Have you ever had kidney disease?
Yes No Do you have any history of psychiatric problems (depression)?
Yes No Do you have any history of immune system disorders?
Yes No Have you received any blood products or immune globulin in the past 3 months?
Yes No Are you pregnant?
Yes No Are you breast feeding?

It is clinic policy that fees are due and payable on the day immunizations are provided.

Once complete please drop this form off with your health centre or public health unit. Yellowknife residents may email a copy to: Nthssa-YK_publichealthadmin@gov.nt.ca

To be completed by Travel Nurse

Health Education

Discussed/Given	Discussed/Given	Discussed/Given
F & W borne diseases	Dengue Fever	Motor Vehicle Accidents
Diarrhea	Ticks	STI
Insect precautions	Japanese Encephalitis	TB
Mosquito Nets	Rabies	Cruises
Sun protection	Altitude Sickness	Travel with Children
Water purifiers	Fresh Water Swimming	Pregnancy & Breastfeeding
First Aid Kits	Bare Feet; Bott Fly	Travax printed info.
		Vaccine info.

Malaria Risk Areas: **No** **Low** **Moderate** **High** **Insect precautions only**

Has client taken anti-malarial medication before? No Yes name of medication.

Previous side effects:

Traveler's Diarrhea Risk: **Low** **Moderate** **High**

Previous Problems**:**

Recommended Medication & Health Education:

Mefloquine _____doses **Malarone _____doses** **Diamox _____doses**

Doxycycline _____doses **Chloroquine _____doses** **WT_________**

Cipro **Zithromax**

Refer to physician _________________________ **Provide PX To: ________________**

Under 5 years of age consult family physician for malaria medications **Faxed ___________**

See progress notes.

Consult Date ______________________ Signature ________________________________

Vaccines: Also see Immunization Record

KEY: ✓: Strongly recommended by Travax **? :** Recommended by Travax (Low-risk) **UTD:** Up to date ------: Not required for this trip

Proposed Schedule			Key		Date	Date	Date	Date	Comments
				Fit to Immunize					
				Hepatitis A					
				Hepatitis B					
				Rabies					
				Japanese Encephalitis					
				Mantoux (TB) Skin Test					
				Measles, Mumps, Rubella					
				Meningococcal Meningitis					
				Pneumococcal Pneumonia					
				Influenza					
				Polio					
				Tetanus/Diphtheria /Pertussis					
				Typhoid					
				Yellow Fever					
				Dukoral					
				Varicella					
				Other					
RN Initials									