CHILLIWACKPHARMACY

Consultation Form

Personal Details

First Name: Last Name:

Date of Birth: Gender: -

Postal Code: Phone: Email:

Emergency Contact

First Name: Last Name: Phone:

Itinerary Details

Destination 1: -	Date of Departure:	Return Date:
Destination 2: -	Date of Departure:	Return Date:
Destination 3: -	Date of Departure:	Return Date:
Destination 4: -	Date of Departure:	Return Date:
Destination 5: -	Date of Departure:	Return Date:

Any further itinerary information *(eg. any overland trips, further planned trips etc.)*

Will you be away from medical help at any of these destinations? ○ Yes ○ No ○ Not sure

Type of trip:
- ○ Business
- ○ Pleasure
- ○ Other

Travelling party:
- ○ Alone
- ○ Family/Friend
- ○ Other

Accommodation:
- ○ Hotel
- ○ Family/Friend Home
- ○ Other

Staying in an area that is:
- ○ Urban
- ○ Rural
- ○ Altitude

Holiday type:
- ○ Package
- ○ Self-organized
- ○ Backpacking
- ○ Camping
- ○ Cruise ship
- ○ Trekking

Planned activities:
- ○ Safari
- ○ Adventure
- ○ Other

Other activities:

CHILLIWACK PHARMACY & TRAVEL CLINIC
101-45863 Yale Rd. Chilliwack, BC V2P 2N6 PHONE: 604-402-3100 FAX :604-402-3101

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Health History

Do you have any medical condition? (including diabetes, heart or lung conditions etc)

○ Yes ○ No

If yes, please explain:

List any current or repeat medications (state 'No' if not applicable):

Do you have any allergies for example to eggs, antibiotics, nuts or latex?

○ Yes ○ No

Have you had a serious reaction to a vaccine given to you before?

○ Yes ○ No

If yes, please explain:

Does having an injection make you feel faint?

○ Yes ○ No

Do you or any close family members have epilepsy?

○ Yes ○ No

Do you have any history of mental illness including depression or anxiety? (for anti-malarial purposes)

○ Yes ○ No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

○ Yes ○ No

If yes, please explain:

Are you pregnant, planning pregnancy or breastfeeding?

○ Yes ○ No

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Health History

Vaccination history:

- ○ Tetanus
- ○ Polio
- ○ Diptheria
- ○ Typhoid
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Meningitis
- ○ Yellow Fever
- ○ Influenza
- ○ Rabies
- ○ Jap B Enceph
- ○ Tick Bourne
- ○ Malaria Tablets
- ○ Other
- ○ Unsure - *can speak with pharmacists at appointment*

If you selected any of the above, let us know when you had these:

By signing and submitting this form I confirm the information provided is accurate and I give permission for Chilliwack Pharmacy to use this information to assess and advise on my travel health needs.

Signature: please sign below

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