

Travel Vaccine Clinic

810 Queen Street East
Toronto, Ontario M4M 1H7
Tel: (416) 461-2419
www.TravelMedicalClinic.com

TRAVEL MEDICAL CLINIC PATIENT INFORMATION SHEET (PLEASE PRINT!)

LAST NAME: _____ FIRST NAME: _____
HOW DID YOU HEAR ABOUT US? Yellow/Pink pages Travel Agent Internet Word of mouth
Been here before Family Doctor Other (Specify): _____
OHIP #: _____ Version Code: _____ (It is the 2 letters after the OHIP number on the photo card OR the letter(s) located on the bottom right hand side of the red & white card. OHIP only covers for the basic shots and blood work.)
Date Of Birth(dd-mm-yy): _____ Sex: Male Female
Address: _____ Apt#: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell : _____ Office : _____ ext _____
Email address: _____
Can we communicate with you via email? Yes No
Do you have private health insurance? Yes No
Did you get here by: TTC Own transportation
Did you come here directly from: Home Other Place (major intersection) _____

For the cost of \$3.00, would you like to receive an immunization record card? Yes No
The Hepatitis A vaccine comes in a two shots, if you prepay for the 2nd Hepatitis A vaccine today, we will waive the \$25 follow-up visit fee. Would you like to take advantage of this offer? Yes No

As a courtesy to you, we will send a report of your vaccinations to your family doctor. (Only if we have the correct information) Please assist us with the following information:

YOUR FAMILY DOCTOR: LAST NAME: _____ FIRST NAME: _____
TELEPHONE #: _____
ADDRESS OR MAJOR INTERSECTION: _____

If you are going on an adventurous trip or into a Malaria zone, for your convenience, you may wish to purchase any of the following specialty items at our clinic.

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Bed Net - Single \$52 Double \$60 | <input type="checkbox"/> Mosquito Head Net \$13.50 | <input type="checkbox"/> Afterbite \$3 | <input type="checkbox"/> Whistle \$2 |
| <input type="checkbox"/> Water purification tablets \$20 | <input type="checkbox"/> Bug Jacket/Pants \$17.58 | <input type="checkbox"/> Afterbite kids \$5.25 | |
| <input type="checkbox"/> Insect repellent \$10 | <input type="checkbox"/> Compass - Read in the dark \$12.98 | <input type="checkbox"/> Lensatic \$9.65 | |
| <input type="checkbox"/> First Aid Kit Extra small \$9.75 | <input type="checkbox"/> Small \$16 | <input type="checkbox"/> Medium \$29.50 | <input type="checkbox"/> Large \$39 |

PLEASE CONTINUE TO FILL OUT THE NEXT 3 PAGES. → → → → → →

For office use

INSURANCE YES ___ NO ___ EMAIL ADDRESS ADDED: YES ___ NO ___ THANK YOU LETTER YES ___ NO ___

DATE: _____ REPORT: YES ___ NO ___ DATE: _____ REPORT: YES ___ NO ___

DATE: _____ REPORT: YES ___ NO ___ DATE: _____ REPORT: YES ___ NO ___

DATE: _____ REPORT: YES ___ NO ___ DATE: _____ REPORT: YES ___ NO ___

Prepaid for Vaccine _____ Yes No Amount _____

Prepaid for Vaccine _____ Yes No Amount _____

Dates of Travel: Departing _____ **Returning** _____

List the countries you plan to visit from first to last:

Name of Country	Area or city	Length of your stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? Please circle.

	Yes	No	Maybe	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Adacel (Td Pertussis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
HIb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____

Have you received any of the following travel vaccinations?

B.C.G (T.B.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Dukoral (Oral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Gardasil (HPV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____ 3 rd dose _____
Influenza (Seasonal Flu shot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Influenza (H1N1 Swine Flu)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Japanese Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____
Measles, Mumps, Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Rabies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____ 3 rd dose _____
Rotateq/Rotarix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
TBE (tick-borne encephalitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Twinrix (Hep A&B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? 1 st dose _____ 2 nd dose _____ 3 rd dose _____
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Zostavax (Shingles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When? _____
Other vaccine(s) _____				When? _____

Medical History:

Please rate your overall health? (Check only one) Poor Fair Good Excellent

Your age _____ Weight if you are under 18 years old _____ kg or _____ lbs.

What country were you born in? _____

If not born in Canada, at what age did you come to Canada? _____

Have you ever had the Hepatitis disease? Yes No If Yes, what type? _____

Are you on any blood thinners, Prednisone, immuno-suppressive or anti-cancer drugs? Yes No

If Yes, what? _____

Are you Allergic to Eggs? Yes No Allergic to Bees? Yes No Allergic to Latex? Yes No

Allergic to Gelatin? Yes No or Allergic to Neomycin? Yes No

Are you allergic to or have any bad reaction to any drugs, foods or vaccines? Yes No

If yes, please specify _____

Have you been sick on any past trips? Yes No If Yes, What happened specifically? _____

HPV vaccine is recommended for males who practice sex with other males and can be given to heterosexual males. Would you like to discuss HPV vaccine with the doctor? Yes No

Check (✓) appropriate boxes () if you Suffer from or have experienced any of the following conditions?

- Heart disease Lung disease Asthma Currently have a fever
- Blindness Deafness Diabetes Dizziness
- Ear Perforations Crohn's Insomnia Traveler's neurosis
- Hepatitis A, B or C Cancer Kidney disease Travel-related phobias
- Motion sickness Psoriasis Phlebitis Traveler's thrombosis (clots)
- Seizures/Epilepsy Stroke Jetlag Immunodeficiency
- Sun allergy Sun Stroke Paranoia AIDS/HIV
- Recurrent Pneumonia Depression Mental illness Low Blood Pressure
- Mountain sickness Handicaps Fear of flying High Blood Pressure
- Fear of Needles Ulcers Ulcerative colitis Other _____
- Splenectomy Excessive susceptibility to heat/cold

Current Medication(s): _____

Do you anticipate being exposed to any of these risks on your trip?

- Extreme heat Swimming Poor sanitation Poor water
- Extreme cold Diving Poor diet Motorcycles
- Extreme stress Physical exertion Trekking or Climbing at high altitude
- High stress High altitude Risk of sexually transmitted disease

Is your trip for business pleasure both?

Please specify the types of trip you are engaging in?

- Staying with family/Relatives Developmental work Business travel in an urban area
- Affluent Travel in a quality hotel Missionary or voluntary work
- Travel in rural or remote areas Backpacking or trekking in mountains/jungles

Emergency Contact Name: _____ **Phone #:** _____

THIS 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 fainted or felt dizzy after vaccination in the past? Yes No
If yes, you MUST remain in the clinic for 20 minutes following vaccination(s).

You may be covered for the cost of vaccines if you have a high quality insurance plan. Phone numbers for most insurance company are posted in waiting area. You may wish to call your insurance company while you are waiting to see the doctor to find out if you are covered. We also advise you to call your family doctor to find out if you have had any vaccinations in the last 10 years. You can also get a record of school vaccines by calling Toronto public health at (416) 392-1250.

***** PLEASE READ AND SIGN *****

I understand that this visit and the vaccinations are not covered by OHIP. The initial visit fee is \$65.00 per person plus the cost of vaccines. The follow-up visit fee regarding the same trip and/or booster shots are \$25.00 plus the cost of vaccines. Charges for doctor's visits and vaccinations apply as you receive them. We do not accept cheques for payment. All prices are subject to change without notice.

I declare that all information provided on this form is accurate to the best of my knowledge and that any inaccurate information maybe detrimental.

Signature of Patient OR Guardian _____ **Date** _____