

LONG SAULT PHARMACY

PRE-TRAVEL FLOW SHEET

Assigned Sex at Birth:		Age:	
Initials of your Name:			
Departure Date:			
How did you hear about our clinic?			
List the countries you plan to visit, in order:			
Country	Duration	Specific Destination	

MEDICATIONS

Are you taking any medication?	☐ Yes ☐ No
List the name of medication:	
Are you taking pills for epilepsy, or blood thinners?	

MEDICAL HISTORY

Do you have any medical problems?	☐ Yes ☐ No
If so, please list them:	

HEPATITIS-A IMMUNITY

Have you had hepatitis disease or jaundice?	☐ Yes ☐ No
If so, please explain:	
Did you grow up outside of Canada?	☐ Yes ☐ No
If yes, where have you lived?	

IMMUNE DEFICIENCY

Have you had your spleen removed?	☐ Yes ☐ No
Are you taking cortisone pills (prednisone, medrol)?	☐ Yes ☐ No
Have you had, or do you have: AIDS, HIV, leukemia, cancer, lymphoma?	☐ Yes ☐ No
Have you been treated with radiation, anti cancer drugs or immune-suppressive drugs?	☐ Yes ☐ No

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ALLERGIES/INTOLERANCES

To the best of your knowledge, are you allergic to:

A) Any medication?

☐ Yes ☐ No

If yes, which one(s)?

B) Eggs or chicken?

☐ Yes ☐ No

C) Any vaccine?

☐ Yes ☐ No

D) Steptomycin, neomycin, polymycin B?

☐ Yes ☐ No

E) Anything else?

☐ Yes ☐ No

Have you ever fainted or felt very unwell after receiving an injection?

☐ Yes ☐ No

ANTI-MALARIALS

As far as you know, do have problems with:

A) psoriasis (skin problem)?

☐ Yes ☐ No

B) liver disease or alcoholism?

☐ Yes ☐ No

C) disease of the retina of your eye?

☐ Yes ☐ No

Have you ever had:

A) a bad depression?

☐ Yes ☐ No

B) psychotic episode?

☐ Yes ☐ No

C) a convulsion (seizure)?

☐ Yes ☐ No

D) a heart problem?

☐ Yes ☐ No

E) kidney disease?

☐ Yes ☐ No

WOMEN ONLY

Is there a chance you are pregnant?

☐ Yes ☐ No

Are you breast feeding?

☐ Yes ☐ No

Do you plan to get pregnant in the next month?

☐ Yes ☐ No

Are you taking the birth control pill?

☐ Yes ☐ No

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YOUR IMMUNIZATION HISTORY

Are you a regular immunization up-to-date?

☐ Yes

☐ No

☐ Not sure

When was the date of your last tetanus shot?

Date (dd/mm/yyyy):

☐ Not sure

Have you had the:

Annual flu vaccine

☐ Yes

☐ No

☐ Not sure

Pneumonia vaccine

☐ Yes

☐ No

☐ Not sure

Chicken pox vaccine

☐ Yes

☐ No

☐ Not sure

MMR vaccine

☐ Yes

☐ No

☐ Not sure

Have you ever had the following immunization?

Hepatitis A

☐ Yes

☐ No

☐ Not sure

Hepatitis B

☐ Yes

☐ No

☐ Not sure

Rabies

☐ Yes

☐ No

☐ Not sure

Yellow Fever

☐ Yes

☐ No

☐ Not sure

Japanese encephalitis

☐ Yes

☐ No

☐ Not sure

Tick borne encephalitis

☐ Yes

☐ No

☐ Not sure

Typhoid

☐ Yes

☐ No

☐ Not sure

Dukoral

☐ Yes

☐ No

☐ Not sure

Meningitis

☐ Yes

☐ No

☐ Not sure