**Instructions**

1. This Pre-Travel Questionnaire is to be filled out by each traveller and **returned to Palliser Medical Clinic at least 2-3 days prior to your travel consult appointment.** It may be returned in one of three ways:
	1. **In person** to the clinic at #210, 740 – 4th Ave South, Lethbridge
	2. **By fax** to (403) 381-4011
	3. **By email** to travel@pallisermedicalclinic.com
2. This document is compatible with Microsoft Word 2010.

**Pre-Travel Questionnaire**

|  |  |
| --- | --- |
| First Name: Click here to enter text. | Date of birth: Choose an item. - Choose an item. - Choose an item. |
| Last Name: Click here to enter text. | Provincial Health Care #: Click here to enter text. |
| Gender: Click here to enter text. | Alberta : ☐ Other: ☐Specify: Click here to enter text. |
| Phone (H): Click here to enter text. | Email: Click here to enter text. |
| Phone (C): Click here to enter text. | Street Address: Click here to enter text. |
| Phone (W): Click here to enter text. | City: Click here to enter text.Postal Code: Click here to enter text. |

1. Departure date from Canada: Click here to enter text.
2. Return date to Canada: Click here to enter text.
3. In the table below, please list all countries and **CITIES** you are planning on travelling to, as well as all the activities you are planning on doing. The first line is an example.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country +CITY** | **Length of Stay** | **Visiting Rural or Forested Areas** | **Expected Animal Contact** | **Adventure Trips**(Safari, kayaking, hiking, camping) |
| *Ex. Mexico* | *2 weeks* | *☐* | *☒ Swimming with dolphins* | *☒ Water Skiing, snorkeling, boat tours*  |
| Click here to enter text. | Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |
| Click here to enter text. | Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |
| Click here to enter text. | Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |
| Click here to enter text. | Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |  [ ]  Click here to enter text. |

1. Reason for travel: Click here to enter text.
2. Where will you be staying? (Select all that apply)
	1. [ ] Camps
	2. [ ] Family
	3. [ ] Hostels
	4. [ ] Hotel
	5. [ ] Other: Click here to enter text.
3. Mode(s) of transportation: Click here to enter text.
4. Do you have any layovers en route to your destination? [ ]  No [ ]  Yes
	1. If yes, please fill out table below.

|  |  |
| --- | --- |
| **Layover Country + CITY** | **Length of Layover** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

1. Are your childhood vaccinations up to date? [ ]  No [ ]  Yes
	1. If no, please explain: Click here to enter text.
	2. If yes, please contact the Community Health Office where you received vaccinations and have them fax your records to us @ 403-381-4011, if possible.
2. Have you received any immunizations within the last 10 years? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
3. Do you have any allergies? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
4. Have you had any allergic reactions to previous vaccinations in the past? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
5. Do you have any allergies to eggs? [ ]  No [ ]  Yes
6. Do you have any allergies to latex? [ ]  No [ ]  Yes
7. Do you have any medical conditions? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
8. Do you take any prescription, over the counter, or herbal medications? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
9. Have you been diagnosed with HIV or malignant neoplasm, or have you had a recent transplant or chemotherapy? [ ]  No [ ]  Yes
	1. If yes, please explain: Click here to enter text.
10. Have you received any blood products (including WinRho) in the last 6 weeks? [ ]  No [ ]  Yes
	1. If yes, please list: Click here to enter text.
11. Are you:
	1. Pregnant? [ ]  N/A [ ]  No [ ]  Yes
	2. Breast feeding? [ ]  N/A [ ]  No [ ]  Yes
12. Were you:
	1. Born in Canada? [ ]  No [ ]  Yes
	2. Raised in Canada? [ ]  No [ ]  Yes
		1. If no, where were you born/raised? Click here to enter text.
13. Any anticipated surgery or medical treatment while traveling? [ ]  No [ ]  Yes
	1. If yes, please explain: Click here to enter text.
14. Any sight-seeing or planned activities while on trip? [ ]  No [ ]  Yes
	1. If yes, please explain: Click here to enter text.
15. In order to provide the best continuity of care for you, once your appointment is completed, we would like to send an FYI letter to your family doctor to inform him/her that you sought travel advice from us. We will NOT disclose ANY information about your visit, not even your destination.
	1. First name Click here to enter text.
	2. Last name Click here to enter text.
	3. Clinic Click here to enter text.
	4. City/town name Click here to enter text.