Travel Health Network
VACCINATION CLINIC & CONSULTANTS

Pre-Travel Questionnaire

Please bring **completed questionnaire, travel itinerary** and any **vaccine records** with you to your appointment. We look forward to serving you.

First Name: _____

Last Name: _____

☐ **I have attended the clinic before. There are no changes to my personal information in the box below.**

Address: _____ Date of Birth: _____

_____ Postal Code: _____ ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____ Family Dr. _____

Email Address: _____ AB Healthcare # _____

Travel Plans? **Date of Departure:** _____

Country?	How Long?		
_____	_____	☐ Vacation	☐ Tour
_____	_____	☐ Business	☐ Self-Planned
_____	_____	☐ Volunteer/Mission	
_____	_____		

Activities planned during travel include:

☐ Diving ☐ Snorkeling or surfing ☐ Travel to rural/remote areas ☐ Providing medical care

☐ Camping/Trek ☐ High Altitude ☐ Back-packing/Hostels ☐ Restricted work camp

Do you have (or have you had) any of the following medical conditions? ☐ **None**

☐ High blood pressure	☐ Emotional/Psychiatric	☐ Liver or kidney disease
☐ High cholesterol	☐ Lung condition (Asthma/COPD)	☐ Damaged/Removed Spleen or Thymus
☐ History of blood clots	☐ Migraines or headaches	☐ Recent chemo or radiation (4 mths)
☐ Taking blood thinner	☐ Diabetes	☐ Organ or bone marrow transplant
☐ Heart disease or arrhythmia	☐ IBS or Digestive tract problems	☐ Immune suppressed or compromised
☐ Seizure disorder	☐ Acid reflux or heartburn	☐ Psoriasis

Other: _____

Current Medications? _____

Are you pregnant, planning to be become pregnant or breastfeeding? ☐ No ☐ Yes ☐ Not applicable

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First Name: _____

Last Name: _____

Please tell us about any reactions, allergies or sensitivities you have:

☐ Eggs or Chicken ☐ Latex ☐ Adhesive Bandages

Allergies _____

Do you have (or have you ever) carried an Epi-Pen? ☐ No ☐ Yes (Why?) _____

Have you ever fainted after an injection? ☐ No ☐ Yes

Do you have a fear of needles? ☐ No ☐ Yes

Weight _____

Typical Blood Pressure (if known) _____

Have you had any vaccinations in the past 4 weeks? ☐ No ☐ Yes (Which one?) _____

How did you hear about our clinic? _____

Please print and bring form. We look forward to seeing you.

Below is For Clinic Use

Consult Fees

	Single	Couple	Family
Standard Consult	$60	$110	$150
Basic Consult - *Mexico, Caribbean, USA and Western Europe*	$45	$80	$100

Family maximum is 4 persons. Each additional family is member $35 / $25 x ____. Prices subject to change

***number of vaccines in series**

Hep A/Typhoid	$110	Meningitis A,C,Y,W135	$130
Typhoid Injectable	$70	Meningitis B **	$145
Tetanus/Diphtheria (Td)	$25	Japanese Encephalitis**	$220
Td + Pertussis (Tdap)	$45	Influenza	Free
Tdap + Polio	$85	HPV - Gardasil 9***	$190
Polio	$85	Mantoux	$50
Pneumococcal 13	$120	Rabies***	$220
Yellow Fever	***$150***	Pneumococcal 23	$25
Typhoid Oral	***$70***	Shingles (Shingrix) **	$160
		Shingles (Zostavax)	***$205***
		Measles/Mumps/Rubella **	***$70***

Hepatitis	A**	B ***	A and B***
Adult	$75	$55	$85
Child	$55	$45	$60

Notes:

_____ Reviewed live vaccine risk.

I, _____ understand the risks and benefits of vaccination and consent to receiving the vaccines indicated above. I am also aware that it is recommended that I remain in the clinic to be monitored for 15 minutes after vaccination.

Signature: _____ Date: _____