D&M PHARMACY

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:

South: 2105, 1800 194th Avenue SE, Calgary, AB T2X 0R3 | Phone: 403-457-7110 | Fax: 403-457-7040
North: 1505 19 Street NW, Calgary, AB T2N 2K2 | Phone: 587-353-0377 | Fax: 587-353-0375
info@travelpharmacy.ca | www.travelpharmacy.ca

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Health History

Do you have any recent or past history of note? (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

Have you taken out any travel insurance, and if you have a medical condition, informed the insurance company about this?

- Yes
- No

Please write below any further information which may be relevant:

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 D&M Pharmacy to use this information to assess and advise on my travel health needs.

Signature: please sign below (don't worry if you are having trouble, we can take your signature again in clinic)

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