TRAVEL HEALTH QUESTIONNAIRE

Please print this form and bring it with you to your appointment.

Clinique Santé Voyage Horizon
2225, chemin Gascon
Terrebonne, QC J6X 4H3
(450) 471-1047

Personal Information

Last name :	First name :	
Address :		
City :		
Province :	Country :	Postal Code :
Telephone (home) :	( ) -	
Telephone (other) :	( ) -	
Date of birth (DD/MM/YYYY) :	(_ _ / _ _ / _ _ _ _)	Gender : ☐ F ☐ M

Destination

Main country to be visited	**Name**	**Cities or regions**	**Duration**
1st country			
2nd country			
3rd country			
4th country			
Departure date :		Return date :	

Type of Travel

☐ Humanitarian aid
☐ Adoption
☐ Student exchange
☐ Family and/or friend visit
☐ Business
☐ Other : _____

☐ Cruise
☐ Resort (all inclusive)
☐ Apart./condo rental
☐ Catamaran / sailboat
☐ Trip with children

☐ Off the beaten track
☐ Underwater diving
☐ High altitude
☐ Independent/solo
☐ Group

To be filled out by women only

Are you pregnant ? ☐ YES ☐ NO ☐ I don't know
If yes, how many weeks ? _____
Are you breastfeeding ? ☐ YES ☐ NO

Medical condition (if any particular medical condition, check here: ☐)

Have you had a medical checkup over the last year? ☐ YES ☐ NO

How long ago? _____

Do you suffer or have you ever had…

☐ Anxiety	☐ Depression/Mood disorders	☐ Dreams/nightmares
☐ Cancer	☐ Trouble du Thymus	☐ Epilepsy/convulsions
☐ Diabetes	☐ Digestive problems	☐ Crohn's disease
☐ High blood pressure	☐ Respiratory disorders	☐ Liver disease, hepatitis
☐ Immune deficiency/HIV	☐ Cardiovascular disorders	☐ Renal problems
☐ Psoriasis	☐ Photosensitivity	☐ Guillain-Barre syndrome
☐ Rheumatoid arthritis	☐ Organ transplant	☐ Autre : _____

Have you ever had any operations? ☐ NO ☐ YES Please specify: _____

Medication (if no medication, check here: ☐)

☐ Antiviral	☐ Insulin/ oral antidiabetics	☐ Corticosteroids
☐ Anticoagulants	☐ Heart medication	☐ Chemotherapy
☐ Beta-adrenergic blocking agent	☐ Cholesterol medication	
☐ Antidepressants/Mood-stabilizing agents	☐ Other : _____	

Allergies (if no allergy, check here: ☐)

☐ Gentamicin	☐ Lactose	☐ Tetracycline	☐ Phenol
☐ Penicillin	☐ Eggs	☐ Streptomycin	☐ Sulfa (Septra, Bactrim)
☐ Latex	☐ Wasps	☐ Thimerosal	
☐ Food: _____		☐ Other : _____	

The following information will be completed at the time of your appointment at the Clinique santé voyage Horizon.

The information provided in this travel health questionnaire is, to the best of my knowledge, exact and true to the state of my health.

Signature _____ **date** _____

* **I accept** the following recommendations :

- *The recommendations are based on my current state of health, my immunization history, my travel destination and my current physical condition.*
- *I have been adequately informed and all my questions have been answered.*
- *I accept to wait 20 minutes at the clinic after having gotten my vaccine.*

- vaccines: _____
- prescriptions: against malaria | treatment of traveler's diarrhea | prevention of high-altitude sickness

Signature _____ **date** _____

***I refuse** the immunization and/or prescription recommendations:

- accines: _____
- prescriptions : against malaria | treatment of traveler's diarrhea | prevention of high-altitude sickness

Signature of nurse _____ **date** _____