CLIENT HEALTH RECORD #

CLIENT SURNAME

GIVEN NAME

DATE OF BIRTH

SEX

MB HEALTH #

PHIN #

TRAVEL HEALTH RECORD

Date: _____

Date of Departure: _____ **Total Length of Trip:** _____

Places to be Visited: (IN ORDER OF TRAVEL ITINERARY)

Country	Town/Cities	Rural	Urban	Dates: From	To

Purpose of Travel (check all that apply)

☐	Adoption	☐	Business *(e.g., meetings, conference)*
☐	Elite Athlete	☐	Medical Tourism
☐	Religious *(e.g., pilgrimage, Hajj, Umrah, retreat)*	☐	Other *(specify)*
☐	Student *(e.g., exchange student, language training, education, research)*		
☐	Tourist *(e.g., vacation, resort, group tour, cruise, backpacking, eco-challenge)*		
☐	Visiting Family in Country of Origin		
☐	Work Abroad *(e.g., development work, missionary work, volunteer, heatlhcare)*		

Accommodation (check all that apply)

☐	Hotel
☐	Hostel
☐	Camping
☐	Local Family & Friends, including Billet
☐	Cruise Ship
☐	Other:

PERSONAL HEALTH HISTORY:

- Do you have any allergies *(e.g., to medication, food [including eggs], vaccines, environmental, latex, insect bites or stings)*?
  ☐ NO ☐ YES Describe _____
- Your present health is... ☐ Good ☐ Other Describe _____
- Do you have, or have you had any of the following:
  - Health conditions that require regular visits to a doctor? ☐ NO ☐ YES Describe _____
  - Conditions that affect your immune system? *(e.g., chemotherapy, HIV/AIDS, steroid use, organ transplant)* ☐ NO ☐ YES Describe _____
  - Thymus gland surgery or disorder? *(myasthenia gravis, DiGeorge syndrome, thymoma, thymectomy)* ☐ NO ☐ YES Describe _____
  - Guillain-Barré Syndrome? ☐ NO ☐ YES Describe _____
  - History of convulsions (seizures)? ☐ NO ☐ YES Describe _____
- Provide list of current medications: *(e.g., prescription, non-prescription, supplements & herbal)*

Name of Medication:	What Medication is Used for:

- Have you had a reaction to a vaccine in the past? ☐ NO ☐ YES Describe _____
- Have you had a fever in the last 24 hours? ☐ NO ☐ YES Describe _____
- Have you had any immunizations in the last month, or any blood products in the last year? ☐ NO ☐ YES Describe _____

For Women Only – Are you:

- Currently pregnant? ☐ NO ☐ YES Due Date _____
- Considering becoming pregnant in near future? ☐ NO ☐ YES Describe _____
- Currently breastfeeding? ☐ NO ☐ YES

Client/Client Representative's Signature: **Date:**