

Questions préliminaires au voyage

Pre-Travel Questionnaire

A Personal Information				
Name: _____	Birth Date: _____	Health Card #: _____	Phone #: _____ <i>(no spaces)</i>	
Address: <i>Street/Apt.</i> _____		<i>City</i> _____	<i>Prov</i> _____	<i>Post. Code</i> _____

B Medical Profile				
	No	Yes		
1. Do you currently have cancer?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have a history of seizures or convulsions?	
2. Have you had cancer within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you ever had hepatitis?	
If yes, what treatment did you have?			10. Do you have diabetes?	
Surgery <input type="checkbox"/>			If yes, how do you treat it?	
Radiotherapy <input type="checkbox"/>			Insulin <input type="checkbox"/>	
Chemotherapy <input type="checkbox"/>			Tablets <input type="checkbox"/>	
			Diet Alone <input type="checkbox"/>	
3. Are you currently receiving oral steroids?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you have heart disease or high blood pressure?	<input type="checkbox"/>
If yes, indicate dosage: _____			12. Are you taking medication for irregular heartbeat (antiarrhythmics)?	<input type="checkbox"/>
4. Do you have lung disease (bronchitis, emphysema, asthma) ?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have liver disease?	<input type="checkbox"/>
5. Do you have AIDS or are you HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have kidney disease?	<input type="checkbox"/>
6. Are you allergic to or have severe reactions to:			15. Do you have a duodenal or gastric ulcer?	<input type="checkbox"/>
Eggs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have ulcerative colitis or Crohn's disease?	<input type="checkbox"/>
Sulfa Drugs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you have ear or eye problems?	<input type="checkbox"/>
Tetracyclines <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Do you have a history of psychosis?	<input type="checkbox"/>	<input type="checkbox"/>		

C Women Only	
Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Last normal menstrual period _____

D Medications	
<input type="checkbox"/> Current Medication With Prescription	_____
<input type="checkbox"/> Current Medication Without Prescription	_____
<input type="checkbox"/> Vitamins, Herbal Products	_____

E Allergies	
Do you have any allergies? <input type="checkbox"/> Medications _____	<input type="checkbox"/> Environmental _____
If yes, specify: <input type="checkbox"/> Food _____	_____

F**Vaccination History**

Indicate which of the following vaccines you have received.

Name	Yes	Date Last Received <i>e.g. November 1995</i>
Tetanus/diphtheria (Td)	<input type="checkbox"/>	
Tetanus/diphtheria/polio (TdP)	<input type="checkbox"/>	
Adacel or Boostrix (DTap/Tdap)	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	
Mumps, Measles, Rubella (MMR)	<input type="checkbox"/>	
Influenza	<input type="checkbox"/>	
Pneumococcal	<input type="checkbox"/>	
TB Skin Test (Mantoux)	<input type="checkbox"/>	
BCG	<input type="checkbox"/>	
Hepatitis A	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	

Name	Yes	Date Last Received <i>e.g. November 1995</i>
Twinrix (A+B)	<input type="checkbox"/>	
Typhoid - Injection	<input type="checkbox"/>	
Typhoid - Oral	<input type="checkbox"/>	
Vivaxim (Hep A + Typhoid)	<input type="checkbox"/>	
Meningococcal	<input type="checkbox"/>	
Yellow Fever	<input type="checkbox"/>	
Japanese Encephalitis	<input type="checkbox"/>	
Dukoral	<input type="checkbox"/>	
Cholera	<input type="checkbox"/>	
Rabies	<input type="checkbox"/>	

G**Type of Travel**

Check each travel category applicable to your trip.

- Affluent tourism - hotels in urban or resort areas
- Hostels, "pensions", with minimal day time only travel
- Business or executive travel - international hotels, staying in urban areas only
- Rural travel, villages, farms, small towns, safari, camping: including overnight exposure
- Working - *Indicate the types of work you will be engaged in during your travel:*
- | | |
|---|---|
| <input type="checkbox"/> Nurse, physician, hospital tech. | <input type="checkbox"/> Engineer |
| <input type="checkbox"/> Missionary | <input type="checkbox"/> Airline employee |
| <input type="checkbox"/> Anthropologist | <input type="checkbox"/> Spelunker |
| <input type="checkbox"/> Veterinarian, animal handler | <input type="checkbox"/> Others: _____ |
- Education - academic work, teaching and study
- Staying with relatives or friends (local's home)
- Cruise, departing from: _____
- Piloting an airplane during your trip

H**Duration of Travel**

Date of departure from Ottawa:

Date of return:

I

Itinerary

Please list, ***in order***, the countries you plan to visit. Indicate the regions or cities you plan to visit, the month of the year (e.g., June) you plan to be in each country and the number of days you will spend in each country..

	<u>Name of Country</u>	<u>Regions or Cities</u>	<u>Month (of the year)</u>	<u>Number of days</u>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				