

CureX Medical Vaccine Centre
380 King St N, Unit 5
Waterloo, Ontario
TEL: (519) 579-8858.
FAX: 226-777-8211

You MUST remain in the clinic for 15 minutes following vaccination(s).

PATIENT INFORMATION (To be completed by the traveller) Date: ___/___/___ (DD/MM/YYYY)

Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your responses.

Gender: Male Female Age: _____ Date of birth: ___/___/___ (DD/MM/YYYY)

Last name: _____ First name: _____

Street: _____ City: _____ Province: _____

Country: _____ Postal code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____ @ _____ Weight (if under 18 yrs): _____ lbs kg

In what country were you born? _____ If not in Canada, at what age did you come to Canada? _____

Job title: _____

Emergency contact: _____ Phone: _____

Your Family Doctor: Last Name: _____ First Name: _____

MEDICAL INFORMATION

Please rate your overall health? (Check only one) Poor Fair Good Excellent AGE: _____

Allergies: Eggs: Yes No *Wasp/Bees: Yes No *Latex: Yes No *Neomycin: Yes No *Gelatine: Yes No *Seasonal Allerg: Yes No

Have you ever had the Hepatitis disease? Yes No If Yes, what type? A B C

Are you allergic to or have any bad reaction to any drugs, foods or vaccines? Yes No If Yes, please specify: _____

Have you fainted or felt dizzy after vaccination in the past? Yes No

Are you on any blood thinners, Prednisone, immunosuppressive or anti-cancer drugs? Yes No If Yes, please specify: _____

Have you been sick on any past trips? Yes No If Yes, what happened? _____

Check () appropriate boxes, if you suffer from or have experienced any of the following conditions?

- | | | | | | |
|--|---|------------------------------------|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sun allergy |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Ear Perforations | <input type="checkbox"/> Depression | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Sun Stroke |
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Fear of flying | <input type="checkbox"/> Cancer | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> Recurrent Pneumonia |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Currently have a fever | <input type="checkbox"/> Mountain sickness | <input type="checkbox"/> Fear of Needles |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Stroke | <input type="checkbox"/> Jetlag | <input type="checkbox"/> Traveler's thrombosis | <input type="checkbox"/> Other: _____ |

CURRENT MEDICATION(S):

Have you taken any of the following for malaria prevention? If yes, check the () appropriate boxes and state if you experienced any side effects:
Mefloquine Malarone Doxy Chloroquine Other: _____

THE SECTION INSIDE THIS BOX IS FOR FEMALES ONLY

Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you trying to get pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you/will you be breast feeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had an abnormal Pap Test result?	Yes <input type="checkbox"/> No <input type="checkbox"/>

ITINERARY Departure date: _____ / _____ / _____ (DD/MM/YYYY) Duration of trip: _____

Please, list all countries and regions you will visit (including stop over) during your trip		
NAME OF COUNTRY	AREA OR CITY	LENGTH OF YOUR STAY

Purpose of your trip:	Business <input type="checkbox"/>	Pleasure <input type="checkbox"/>	Both <input type="checkbox"/>
Do you anticipate being exposed to any of these risks on your trip?			
<input type="checkbox"/> Extreme heat	<input type="checkbox"/> Physical exertion	<input type="checkbox"/> Swimming	<input type="checkbox"/> Poor water
<input type="checkbox"/> Extreme cold	<input type="checkbox"/> High stress	<input type="checkbox"/> Diving	<input type="checkbox"/> Motorcycles
<input type="checkbox"/> Extreme stress	<input type="checkbox"/> High altitude	<input type="checkbox"/> Trekking or Climbing	<input type="checkbox"/> Risk of sexually transmitted disease

Please specify the type(s) of trip you are engaging in?		
<input type="checkbox"/> Staying with family/Relatives	<input type="checkbox"/> Missionary or voluntary work	<input type="checkbox"/> Developmental work
<input type="checkbox"/> Affluent Travel in a quality hotel	<input type="checkbox"/> Travel in rural or remote areas	
<input type="checkbox"/> Business travel in an urban area	<input type="checkbox"/> Backpacking or trekking in mountains/jungles	

VACCINATION RECORD HISTORY	Were you fully vaccinated as a child? YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you had the following routine immunization/vaccines in the last 10 years? Check the () appropriate boxes.	

Prior immunizations:	yes	no	don't know	approx. date
Tetanus-Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Act – HIB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2:
Rotatex/Rotarix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B.C.G (T.B.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Measles, Mumps, Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2:
Bexsero	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2: #3:
Influenza vaccine (flu shot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gardasil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2: #3:
Dukoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A vacc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2:
Hepatitis B vacc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2: #3:
Twinrix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2: #3:
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Injectable Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Japanese Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2
Pneumonia vaccine Pn 23 <input type="checkbox"/> Pr 13 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rabies vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DOSE: #1: #2: #3:
Tick Borne Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zostavax (Shingles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE READ AND SIGN

I understand that this visit and the vaccinations are not covered by OHIP. Our consultation fee is \$80 per person or \$120 for family (upto 4 family members, additional member \$40 each). The follow up fee for booster shots is \$20.00 per person plus the cost of the vaccines. All prices are subject to change without notice. We accept visa and mastercard credit cards and interac.

I agree to stay seated in the waiting room for observation for 15 minutes after vaccination of all vaccines, with the exception of the yellow fever vaccine for which I will remain seated in the waiting room for 30 minutes after vaccination. I declare that all information provided on this form is accurate to the best of my knowledge and that any inaccurate information maybe detrimental. I consent to be treated by any of the following people: Canadian or International Medical Graduate.

SIGNATURE OF PATIENT OR GUARDIAN:	DATE:
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