ZINOHA PHARMACY Pre-travel Clinic- Risk Assessment Form

Travel Health Consultation (Please fill the entire form except for office use columns and e-mail us at: travel@zinohapharmacy.com or fax to us: at **403-238-3383**)

Health Travel Counseling given		Yes		No	
Consent for administration of injection taken		Yes		No	

Name:	**D.O.B.**_____ **(DD/MM/YYYY)**	**Gender**(circle one) **: M / F** **AB Health Number:**_____ **Insurance coverage (drug):** _____ (or e-mail or fax separately)
Client's address & Phone #:	Family Doctor's name :	

Medical history:

Current medical problems:		Current medication:							
Allergies:		**Pregnancy?**	Yes		No		N/A		Number of weeks

TRAVEL DETAILS: (In order first to last).	**Date of departure:** _____ **(DD/MM/YYYY)**	**Total duration:**		
Destination (s): (Record number of days in box)	Country: ____ days	Country: ____ days	Country: ____ days	Country: ____ days	Country: ____ days
	Country: ____ days	Country: ____ days	Country: ____ days	Country: ____ days	Country: ____ days

Type of trip (please tick all that apply)						**Area to be visited**		**Accommodation**	
Package holiday		Immigration		Voluntary charity wok		Urban		Good	
Cruise		Organized adventure holiday		Elective/Student		Rural		Basic	
Business less than 3 months		Backpacking		Aid worker		Altitude >3000m		Poor	
Business more than 3 months		Visiting family and friends		Self-organised		Beach		Not known	

Occupation/ activities abroad:

Subsequent notes (for office use)

Date:	**Date:**	**Date:**

(for office use)

Risk discussed:			
Bite avoidance			
Food/ water hygiene			
Blood borne viruses			
Rabies			
Schistosomiasis			
Insurance / accidents			
Sun protection			
Other (Please specify here):			

Final Remarks:

TKD