

**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](mailto: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	
<b>Name:</b>		<b>D.O.B.</b> _____ (MM/DD/YYYY)		<b>Gender</b> (circle one) : <b>M / F</b> <b>AB Health Number:</b> _____ <b>Insurance coverage (drug):</b> _____ (or e-mail or fax separately)	
Client's address & Phone #:		Family Doctor's name :			
Medical history:					
Current medical problems:		Current medication:			
Allergies:		<b>Pregnancy?</b> Yes		No	N/A
				Number of weeks	
<b>TRAVEL DETAILS: (In order first to last).</b>		<b>Date of departure:</b> _____ (MM/DD/YYYY)		<b>Total duration:</b>	
<b>Destination (s):</b> ( Record number of days in box)	Country:	Country:	Country:	Country:	Country:
	_____ days	_____ days	_____ days	_____ days	_____ days
	Country:	Country:	Country:	Country:	Country:
	_____ days	_____ days	_____ days	_____ days	_____ days
<b>Type of trip (please tick all that apply)</b>			<b>Area to be visited</b>		<b>Accommodation</b>
Package holiday	<input type="checkbox"/>	Immigration	<input type="checkbox"/>	Voluntary charity wok	<input type="checkbox"/>
Cruise	<input type="checkbox"/>	Organized adventure holiday	<input type="checkbox"/>	Elective/Student	<input type="checkbox"/>
Business less than 3 months	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>	Aid worker	<input type="checkbox"/>
Business more than 3 months	<input type="checkbox"/>	Visiting family and friends	<input type="checkbox"/>	Self-organised	<input type="checkbox"/>
			Urban	<input type="checkbox"/>	Good
			Rural	<input type="checkbox"/>	Basic
			Altitude >3000m	<input type="checkbox"/>	Poor
			Beach	<input type="checkbox"/>	Not known
<b>Occupation/ activities abroad:</b>			<b>Subsequent notes (for office use)</b>		
<b>(for office use)</b>			<b>Date:</b>	<b>Date:</b>	<b>Date:</b>
<b>Risk discussed:</b>					
Bite avoidance					
Food/ water hygiene					
Blood borne viruses					
Rabies					
Schistosomiasis					
Insurance / accidents					
Sun protection					
Other (Please specify here):					
Final Remarks:					

TKD