Centre de santé et de services sociaux des Îles

EVALUATION FORM – TRAVEL CLINIC

Date : _____

IDENTITY

Name : _____ File number : _____

Date of birth : _____ Place of birth : _____

Phone (home) : _____ Phone (work): _____ Phone (cell) : _____

Departure date: _____ Length of stay:_____

Detailed itinerary: _____

_____

_____

- ❑ Package vacation
- ❑ International collaboration
- ❑ Work
- ❑ City
- ❑ Country
- ❑ Backpacking
- ❑ Single
- ❑ Couple
- ❑ Group

Accommodation

- ❑ Small hotel
- ❑ Big hotel
- ❑ Inn
- ❑ Camping
- ❑ At the inhabitants place
- ❑ Cruise
- ❑ Other _____

Do you travel this way usually? ❑ Yes ❑ No

Did you receive vaccines somewhere else other than the Islands? ❑ Yes ❑ No
If so, attach the proof (vaccination record or other)

Are you interested by an antibiotics prescription against traveller's diarrhea?

❑ Yes ❑ No

Are you interested in receiving a medical prescription protecting you against malaria?

❑ Yes ❑ No

Name your pharmacy _____

(Answer and sign at the back)

TO BE COMPLETED BY THE NURSE

Précautions avec l'eau et les aliments	Fait ❑	Piqûres de moustiques	Fait ❑	Ciguatera	Fait ❑
Morsures de serpents	Fait ❑	MTS-Sida	Fait ❑	Mal des transports	Fait ❑
Plage, soleil, baignade, plongée	Fait ❑	Choc psychologique, alcool	Fait ❑	Rage	Fait ❑
Fièvre pendant ou 3 mois après : consulter	Fait ❑	Assurances et ressources	Fait ❑		
Précautions avec les enfants	Fait ❑	médicales à l'étranger			

Prescription remise :

❑ Azithromycine ❑ Cipro ❑ Chloroquine ❑ Schéma du traitement de la diarrhée

Signature de l'infirmière : _____ N° permis : _____Date :_____

Nom du médecin répondant de la clinique : _____

Do you have one of these illnesses or do you take named medication?

- Intestine İnflammatory illness (Crohn, ulcerous colitis) ❑ Yes ❑ No
- Hepatic illness ❑ Yes ❑ No
- Renal insufficiency (clearance of the Creatinine less than 30cc/min) ❑ Yes ❑ No
- Epilepsy / convulsion ❑ Yes ❑ No
- Heart disease (arrhythmia, cardiac insufficiency) ❑ Yes ❑ No
- Diabetes under insulin ❑ Yes ❑ No
- Polyarthritis rheumatoid ❑ Yes ❑ No
- Pulmonary illness ❑ Yes ❑ No
- Immunosuppressed (HIV, chemotherapy, Etanercept (Enbrel), Methotrexate, Adalimumab (Humira), long term corticosteroid PO: ex.: Pred. 20 mg or more a day, etc.) ❑ Yes ❑ No

Are you allergic to some of these medications? If so, which ones? ❑ Yes ❑ No

❑ Hydroxychloroquine (Chloroquine) ❑ Ciprofloxacine (Cipro) ❑ Levofloxacine (Levaquin)

❑ Moxifloxacine (Avelox) ❑ Clarithromycine (Biaxin) ❑ Azithromaxycine (Zithromax)

Do you take some of these medications? If so, which ones? ❑ Yes ❑ No

❑ Warfarine (Coumadin) ❑ Aminophylline/Oxtriphylline (Theophylline)

❑ Phenytoïne sodique (Dilantin) ❑ Hydroxychloroquine (Plaquenil)

Do you take antiarrhythmic? If so, which ones? ❑ Yes ❑ No

❑ Amiodarone (Cordarone) ❑ Digoxin (Lanoxin) ❑ Quinidine

Do you take antipsychotic, such as Halopérodol (Haldol) ❑ Yes ❑ No

Do you take antidepressant, such as Venlafaxine (Effexor) ❑ Yes ❑ No

Do you have treatments against acne or rosacea? ❑ Yes ❑ No

- Minocycline/tetracycline (Minocin / Tetrex / Vibramycine) ❑ Yes ❑ No

Do you have a retinopathy ❑ Yes ❑ No

Do you have severe psoriasis ❑ Yes ❑ No

Others conditions

Are you under 5 years old or older than 75 years old? ❑ Yes ❑ No

Pregnancy or breast-feeding ❑ Yes ❑ No

Others health problems ❑ Yes ❑ No

Name them: _____

Medication allergy ❑ Yes ❑ No

Name it: _____

Do you take medication ❑ Yes ❑ No

(Please annex your list to the form.)

Signature of traveller: _____ **Date:** _____

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