Travel *Consultation risk assessment form*

pharmadoctor

Patient Travel Consultation Details

Title:		Gender:		Address:	
First Name:					
Surname:				City:	
Date of Birth:				Postcode:	
Telephone:				Country:	
Mobile:				Email:	

Vaccine history	Date		Vaccine history	Date

Destination country	Arrival Date	Departure Date

Medical information (tick either 'Yes' or 'No', as appropriate and provide further details where asked.)		
Y	N	**Are you currently taking any medications (prescription or non-prescription)?** *(if so please give details below)*
Y	N	**Have you had a high fever or temperature in the last 24 hours?** *(If yes, provide cause & length of fever?)*
Y	N	Are you taking any regular medication which thins your blood or prevents it from clotting excluding aspirin 75mg? *(If yes, please provide more details)*
Y	N	Have you had past or recent surgery? *(If yes, please provide more details)*
Y	N	Women only: Are you pregnant, planning pregnancy or breast-feeding? *(If yes, please provide more details)*

Medical information – continued

Y	N	Are you receiving daily injections to thin your blood?
Y	N	Do you have any ongoing medical problems? (If yes, please select the relevant option below)

Diabetes	X		High blood pressure	X		Asthma	X
Epilepsy	X		Kidney disease	X		Liver disease	X
Sickle cell	X		Porphyria	X		Myasthenia gravis	X
Other (provide details)							

Y	N	Do you have any bleeding disorders? *(If yes, please provide more details)*
Y	N	Are you receiving dialysis?
Y	N	Have you been told you may have low immunity? *(If yes, please select the relevant option below)*

Had solid organ / bone marrow / stem cell transplant	X	Have HIV	X
Received chemotherapy or radio therapy in last 6 months	X	Are immunocompromised	X
Taken immunosuppressant in last 6 months	X	Have had your spleen removed	X
Are currently or have taken steroids in the last month	X	On dialysis	X
None of the above	X		X

Y	N	Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine?
Y	N	Have you had any allergies or severe reactions to previous vaccinations? (*If yes, list the vaccines)*
Y	N	Do you have any allergies (*e.g eggs, antibiotics, nuts, medications*)?
Y	N	Do you suffer from thymus dysfunction? *(If yes, please provide more details)*
Y	N	Have you had your school leavers DTP vaccine? *(If yes or unsure, please provide details)*
Y	N	Do you have any cerebral disorders *(e.g. Epilepsy or Stroke)? (If yes, please provide more details)*
Y	N	Have you ever take antimalarials before? (If yes, select all the antimalarial you have taken before.)

Mefloquine	x	Doxycycline	x	Atovaquone/Proguanil	x	Chloroquine	x	Proguanil	x	unsure	x

Y	N	Have you have ever had problems taking any malaria medication before? *(If yes, please provide details)*
Y	N	Have you had a serious liver problem requiring a liver specialist review? *(If yes, please provide details)*
Y	N	Have you had any serious kidney problem with your kidney requiring a kidney specialist review? *(If yes, please provide full history of your kidney condition & any interventions of your kidney condition)*
Y	N	Have you had kidney failure due to malaria or Blackwater fever? *(If yes, please provide details)*
Y	N	Do you or any close family suffer from epilepsy?
Y	N	Have you ever suffered/do you currently suffer from? *(Please answer yes even if the episode was mild or an isolated case, If yes identify below)*

Anxiety	X		Panic attacks	X		Depression	X
Any other psychiatric problems							

Y	N	Are there any other health/medical details you feel we should know? (If yes, please provide details using the full name of the condition(s)