# Travel risk assessment form

Totley Pharmacy
Your Community Pharmacy

## Patient Travel Consultation Details

| Title: | | Gender: | | Address: | |
|---|---|---|---|---|---|
| First Name: | | | | | |
| Surname: | | | | City: | |
| Date of Birth: | | | | Postcode: | |
| **Telephone:** | | | | **Email:** | |

GP Name and Address:

Would you like your GP to be notified of this consultation?

| Vaccine history | Date | | Vaccine history | Date |
|---|---|---|---|---|
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| Destination country | Arrival Date | Departure Date |
|---|---|---|
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| | | |

| **Medical information (tick either 'Yes' or 'No', as appropriate and provide further details where asked.)** | | |
|---|---|---|
| Y | N | **Are you a frequent traveller?** |
| 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?<br>*(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?<br>*(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?<br>(If yes, please provide details using the full name of the condition(s) |
|---|---|---|
| | | |