

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

GP Name and Address:

Would you like your GP to be notified of this consultation? YES NO

Vaccine history	Date	Vaccine history	Date

Destination country	Arrival Date	Departure Date

Reason for travel							
Hajj or other pilgrimage			Visiting friends or relatives			Altitude	
Other (Please specify)							

Medical information		
Y	N	Are you currently taking any medications (prescription or non-prescription)? (if so please give details below)
Y	N	Have you received oral or parenteral antibiotics within the last 14 days?
Y	N	Have you had a high fever or temperature in the last 24 hours? (If yes, provide cause & length of fever?)

Medical information – continued													
Y	N	Are you taking any regular medication which thins your blood or prevents it from clotting excluding aspirin 75mg? <i>(If yes, please provide more details)</i>											
Y	N	Have you had past or recent surgery? <i>(If yes, please provide more details)</i>											
Y	N	Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant? <i>(If yes, please provide more details)</i>											
Y	N	Are you breast-feeding? <i>(If yes, please provide more details)</i>											
Y	N	Do you have any ongoing medical problems? <i>(If yes, please provide more details)</i>											
Y	N	Do you have any bleeding disorders? <i>(If yes, please provide more details)</i>											
Y	N	Are you receiving dialysis?											
Y	N	Have you been told you may have low immunity? <i>(If yes, please provide more details)</i>											
Y	N	Does anyone in your family have a congenital or hereditary immune disorder?											
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? <i>(If yes, list the vaccines)</i>											
Y	N	Do you have any allergies (e.g. eggs, antibiotics, nuts, medications)?											
Y	N	Have you been told by your doctor you have an intolerance to any sugars, (e.g. galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)?											
Y	N	Do you suffer from thymus dysfunction? <i>(If yes, please provide more details)</i>											
Y	N	Have you had your school leavers DTP vaccine? <i>(If yes or unsure, please provide details)</i>											
Y	N	Do you have any cerebral disorders (e.g. epilepsy or stroke)? <i>(If yes, please provide more details)</i>											
Y	N	Have you ever taken antimalarials before? (If yes, select all the antimalarial you have taken before.)											
		Mefloquine	<input checked="" type="checkbox"/>	Doxycycline	<input checked="" type="checkbox"/>	Atovaquone /Proguanil	<input checked="" type="checkbox"/>	Chloroquine	<input checked="" type="checkbox"/>	Proguanil	<input checked="" type="checkbox"/>	Unsure	<input checked="" type="checkbox"/>
Y	N	Have you have ever had problems taking any malaria medication before? <i>(If yes, please provide details)</i>											

Medical information – continued									
Y	N	Have you had a serious liver problem requiring a liver specialist review? <i>(If yes, please provide details)</i>							
Y	N	Have you had any serious kidney problems requiring a kidney specialist review? <i>(If yes, please provide full history of your kidney condition & any interventions of your kidney condition)</i>							
Y	N	Have you had a serious liver problem requiring a liver specialist review? <i>(If yes, please provide details)</i>							
Y	N	Have you had kidney failure due to malaria or Blackwater fever? <i>(If yes, please provide details)</i>							
Y	N	Do you or any close family suffer from epilepsy?							
Y	N	Have you ever suffered/do you currently suffer from any psychiatric problems? <i>(Please answer yes even if the episode was mild or an isolated case, and provide details below)</i>							
		Anxiety	<input checked="" type="checkbox"/>	Panic attacks	<input checked="" type="checkbox"/>	Depression	<input checked="" type="checkbox"/>	Any other psychiatric problems	<input checked="" type="checkbox"/>
Y	N	Have you received any blood products such as antibodies (immunoglobulins) in the last 3 months?							
Y	N	Are there any other health/medical details you feel we should know? <i>(If yes, please provide details)</i>							

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions.

I consent to the recommended medicines being given at each appointment.

Patient /carer signature..... /..... /.....

Date.....

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Further advice/documentation provided

Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV	<input type="checkbox"/>	Leaflets given including PILs	<input type="checkbox"/>
Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accident avoidance	<input type="checkbox"/>	Meningitis (ACWY) certificate given	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection	<input type="checkbox"/>	Yellow Fever certificate given	<input type="checkbox"/>

Malaria Oral Medicine	Date	Quantity	Details	Price
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

For each vaccine add: Date, batch No, expiry date and administration site

Vaccine	Consultation 1	Consultation 2	Consultation 3	Price
Yellow fever				
Meningitis ACWY				
Typhoid				
Combined Hep A + Typhoid				
Combined Hep A + Hep B				
Hep A				
Hep B				
Tick-borne encephalitis				
Japanese encephalitis				
Rabies				
Cholera				
Mefloquine				
Doxycycline				
Atovaquone/ proguanil				
Dip / Tet / Polio				

Pharmacist's signature...../...../.....

Date.....