

Date: \_\_ / \_\_ / 20 \_\_

Patient's personal details	
Title: Mr: <input type="checkbox"/> Miss: <input type="checkbox"/> Ms: <input type="checkbox"/> Mrs: <input type="checkbox"/> Dr: <input type="checkbox"/>	Patient address:
Name:	
Surname:	GP Name and address:
Email:	
Mobile:	Would you like your GP to be notified of this consultation? <input type="checkbox"/>
Gender: M: <input type="checkbox"/> F: <input type="checkbox"/> D.O.B: __ / __ / __	

**Dates, itinerary and purpose of trip**

Date of departure: \_\_\_\_\_ Return date or overall length: \_\_\_\_\_

Country to be visited	Length of stay	Remote? Trek? Medical access? Altitude?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Mode of transport: \_\_\_\_\_

**Personal medical history**

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any immunisations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any recent or past medical history of note?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any current or repeat medicines or are you taking halofantrine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies to any medicines, latex or eggs?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you know if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or any of your family suffer from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a past history of black water fever?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have severe impairment of liver function?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you suffer from any blood disorders such as thalassaemia or sickle cell anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently undergone radiotherapy, chemotherapy, steroids treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?	<input type="checkbox"/>	<input type="checkbox"/>	

**Vaccination history**

Have you had a vaccine, antimalarial or doxycycline before? (Please add dates)

Dip Tet Polio	Typhoid	Hepatitis A
Hepatitis B	Meningitis	Yellow Fever
Rabies	Jap B Encephalitis	Influenza
Shingles	Meningitis B	Tick Borne Encephalitis
MMR	Chickenpox	
Other.....	Malaria Tablets.....	

**Women only**

Tick which of the following applies to you	Yes	No	Details (to be reconfirmed at each appointment)
Are you pregnant or planning a pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

**Please write below any further information which may be relevant e.g. medicines, conditions...**

**FOR OFFICIAL USE**

<b>Consultation Record</b>		<b>For each consultation add:</b> date, batch No, expiry date, administration site and patient consent signature		
<b>Vaccine</b>	<b>Consultation 1</b>	<b>Consultation 2</b>	<b>Consultation 3</b>	<b>Price</b>
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other .....				
Other .....				
<b>Malaria Oral Medicine</b>	<b>Date</b>	<b>Quantity</b>	<b>Details</b>	<b>Price</b>
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

**Total price.....**

**Additional travel advice:**

Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV	<input type="checkbox"/>
Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accidents	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection	<input type="checkbox"/>

**Notes:**

**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 / Guardian signature..... / ..... / ..... Date.....

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

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes / No**