

Travel

Barnton Pharmacy

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. _____	_____	_____

Personal Medical History

Tick which of the following applies to you	Yes	No	Details (reconfirmed @ each appointment)
Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any immunizations 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 radio therapy, 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)

Tetanus	Polio	Diphtheria
Typhoid	Hepatitis A	Hepatitis B
Meningitis	Yellow Fever	Influenza
Rabies	Jap B Enceph	Tick Borne
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...