

Patient's personal details						
Title:	Mr:	Miss:	Ms:	Mrs:	Dr:	Patient address:
Name:						
Surname:						
Email:						GP Name and address:
Mobile:						
Gender:	M:	F:	D.O.B: __ / __ / __			

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.....

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.....

OUR SERVICE IS A PRIVATE SERVICE AND NOT COVERED BY THE NHS

Do you consent to our pharmacy contacting you on other medical services we provide? **Yes / No**

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?

Are you breastfeeding?

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

FOR OFFICIAL USE

Consultation Record		For each consultation add: date, batch No, expiry date, administration site and patient consent signature					
Vaccine	Consultation 1		Consultation 2		Consultation 3		Price
Dip / Tet / Polio	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Typhoid	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Hepatitis A	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Hepatitis B	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Meningitis	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Rabies	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Cholera	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Yellow Fever	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Other	Batch Number AFFIX VACCINE STICKER Administration	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
...							

Malaria Oral Medicine	Date	Quantity	Details	Price
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: