Travel Clinic Pre-Consultation Form

WATERMAN
PHARMACY & TRAVEL CLINIC

Personal details	Date today:
Name Address	Date of Birth: Male [ ] Female [ ]
Mobile Phone Number	
Email	
GP Details	

Dates of Trip
Date of departure:
Return date or overall length:

Itinerary and purpose of visit		Travel propose	
Country to be visited	Length of stay	[] Adventure	[] Cruise
1.		[] Diving	[] Healthcare worker
2.		[] Long-term (backpacker / expatriate / volunteer / work)	[] Medical access?
3.			[] Medical tourism
4.		[] Remote	[] Natural disasters
5.		[] Visiting friends & relatives (VFRs)	[] Pilgrimage
			[] Trek
			[] Other

Personal medical history			
Tick which of the following applies to you	Yes	No	Details (reconfirm at each appointment)
Are you feeling well today? Do you have a fever?			
Do you have any recent or past medical history of note?			
Have you had any immunizations in the past 3 weeks?			
Do you have any allergies to eggs, latex, nuts or antibiotics?			
Do you take any current or repeat medicines?			
Have you had a serious reaction to a vaccine before?			
Does having an injection make you feel faint?			
Do you or any of your family suffer from epilepsy?			
Recently undergone radiotherapy, chemotherapy, steroids?			
Do you have a medical history of the following: anxiety, depression, heart, lung, spleen, joint, liver, kidney, immunity, blood conditions, disorders, diabetes, HIV/AIDS			
Please write below any further information which may be relevant			

Vaccination History					
Have you ever had any of the following vaccinations / malaria tablets and if so when?					
Diphtheria		Hepatitis A		Hepatitis B	
Influenza		Jap B Enceph		Malaria Tablets	
Meningitis		Polio		Rabies	
Tetanus		Tick Borne		Typhoid	
Yellow Fever		Other			

Personal medical history			
Tick which of the following applies to you	Yes	No	Details (reconfirm at each appointment)
Allergies (including food, latex, medication etc.)			
Anaemia			
Bleeding/ clotting disorders (including deep vein thrombosis)			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Heart disease (e.g. angina, high blood pressure)			
HIV/AIDS			
Immune system condition			
Kidney problems			
Liver problems			
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions			

Women only			
Tick which of the following applies to you	Yes	No	Details (reconfirm at each appointment)
Are you pregnant? Or planning a pregnancy?			
Are you breast feeding?			