Chickenpox - Risk Assessment Form 2021 **Date:**

Patient's personal details

Title: Mr: ◯ Miss: ◯ Ms: ◯ Mrs: ◯ Mx: ◯ Dr: ◯	Patient address:
Name:	
Surname:	
Email:	GP Name and address:
Mobile:	
Gender: Male ◯ Female ◯ Prefer not to say ◯	Would you like your GP to be notified of this consultation? Yes ◯ No ◯
Date of Birth:	

Personal medical history

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

Vaccination history

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

Diphtheria, Tetanus & Polio → ☐	Typhoid → ☐	Hepatitis A → ☐
	Meningitis ACWY → ☐	Yellow Fever → ☐
Rabies → ☐	Japanese Encephalitis → ☐	Influenza → ☐
Shingles → ☐	Meningitis B → ☐	Tick Borne Encephalitis → ☐
Hepatitis B → ☐	Chickenpox → ☐	Other → ☐
Malaria Tablets → ☐	MMR → ☐	Other → ☐

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...

Submit Form

Or save, and send as an attachment to:
clinic@monkbarpharmacy.co.uk

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				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other				
Other				

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

Additional travel advice:

Total price.....

Water and personal hygiene	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐
Insect bite prevention	☐	Animal bites	☐	Accidents	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐

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**