

## Occupational Health - Risk Assessment Form

Date:

Patient's personal details						
Title:	Mr:	Miss:	Ms:	Mrs:	Dr:	Patient address:
Name:						
Surname:						GP Name and address:
Email:						
Mobile:						Would you like your GP to be notified of this consultation? Yes    No
Gender:	M:	F:	D.O.B:			

### 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 know 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...**