

**Pneumonia - 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 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...**

**FOR OFFICIAL USE**

<b>Consultation Record</b>		<b>For each consultation add:</b> date, batch No, expiry date, administration site and patient consent signature		
<b>Vaccine</b>	<b>Consultation 1</b>	<b>Consultation 2</b>	<b>Consultation 3</b>	<b>Price</b>
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other .....				
Other .....				
<b>Malaria Oral Medicine</b>	<b>Date</b>	<b>Quantity</b>	<b>Details</b>	<b>Price</b>
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

**Additional travel advice:**

**Total price.....**

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:**

**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**