Travel Clinic Risk Assessment Form (tRAF) **Date:**

Monkbar PHARMACY

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?
Gender: M: ◯ F: ◯ D.O.B:	Yes ◯ No ◯

Dates, itinerary and purpose of trip

Date of departure: Return date or overall length:

Country or Countries to be visited (If possible, be specific with cities or places)	Length of stay	Purpose of visit? Leisure? ◯ Business? ◯ Other? ◯
1.		Remote? ◯ ◯
2.		Trek? ◯ ◯
3.		Medical access? ◯ ◯
4.		Altitude? ◯ ◯ Mode(s) 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?	◉	◯	
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 → ☐
Rabies → ☐	Meningitis ACWY → ☐	Yellow Fever → ☐
Shingles → ☐	Japanese Encephalitis → ☐	Influenza → ☐
Hepatitis B → ☐	Meningitis B → ☐	Tick Borne Encephalitis → ☐
Malaria Tablets → ☐	Chickenpox → ☐	Other → ☐
	MMR → ☐	Other → ☐

Women only

Tick which of the following applies to you	Yes	No	Details (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 (along with any other accompanying documents) to:
travel@monkbarpharmacy.co.uk