

**BRUNTSFIELD MEDICAL PRACTICE**  
**TRAVEL ASSESSMENT FORM – FOR PATIENT COMPLETION**

<b>Name</b>											<b>Date of 1st appointment</b>						
<b>Date of birth</b>											<b>Telephone No.</b>						
<b>Address</b>																	

<b>PERSONAL PROFILE</b>	<b>TRAVEL PROFILE</b>								
<b>Significant past medical history</b>	<b>Reason for travel (Please tick)</b>								
	Work <input type="checkbox"/> Recreational <input type="checkbox"/>								
	<b>Date of departure</b>								
	<b>Travelling to:</b>								
	<b>Country</b>	<b>Length of stay</b>	<b>Rural or city?</b>						
<b>Current health problems</b>	<b>Type of accommodation (Please tick)</b>								
	Hotel <input type="checkbox"/>								
	Apartment <input type="checkbox"/>								
	Hostel <input type="checkbox"/>								
	Tents <input type="checkbox"/>								
<b>Allergies</b>	<b>Others, please specify:</b>								
<b>Pregnant, or planning to be? (Please tick if applicable)</b>									
YES <input type="checkbox"/> NO <input type="checkbox"/>									

**General comments** (previous travel, dates of previous vaccines, etc)

**PRACTICE USE ONLY**

**MALARIA**

<b>Is there a risk of Malaria</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Awareness, understanding of how it is contracted, symptoms</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Bite avoidance (nets, repellents, etc)</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Signs, symptoms, diagnosis</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Written info given to patient</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Weight of child (If applicable)

**WRITTEN OR VERBAL INFORMATION GIVEN**

<b>Food and water</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Insect bites</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Accidents</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Health insurance</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Safe sun</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>DVT prevention</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Safe sex and contraception</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Fit for travel web address</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Malaria tablets</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>
<b>Other, please specify:</b>	WRITTEN <input type="checkbox"/> DISCUSSED <input type="checkbox"/>

**CHEMOPROPHYLAXIS RECOMMENDED**

<b>Chloroquine (patient to buy OTC)</b>	
<b>Proguanil (patient to buy OTC)</b>	
<b>Doxycycline</b>	
<b>Malarone</b>	
<b>Mefloquine</b>	
<b>Emergency standby treatment</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Side effects discussed</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Private prescription requested</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>

**PRACTICE USE ONLY**

Vaccine	Recommended for current trip?	Vaccination, therefore required?	Manufacturer + Batch No.	Site given	Miscellaneous
Tetanus					
Diphtheria					
Polio					
Typhoid					
Hepatitis A					6 month - 1 year booster advised? YES <input type="checkbox"/> NO <input type="checkbox"/>
Hepatitis B		Prescription requested? YES <input type="checkbox"/> NO <input type="checkbox"/>			
BCG					To consult RIE clinic? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Advised to attend travel clinic for further advice?</b>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>Travax printout given to patient?</b>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>Vaccine record card given to patient?</b>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>Further information (If applicable)</b>					
<b>Assessor's signature .....</b>					
<b>Date .....</b>					