

**MALARIA QUESTIONNAIRE FOR PATIENTS REQUIRING ANTI-MALARIAL TABLETS**

(To be completed in addition to the Travel Questionnaire)

**Patient's name** \_\_\_\_\_

**Date of birth** \_\_\_\_\_

1. Have you, or a member of your immediate family, ever been, or are you presently, on any treatment for depression, anxiety or any psychiatric disorder?

YES  NO

2. Do you, or any of your immediate family, suffer from epilepsy or fits?

YES  NO

3. Do you have any liver or kidney problems?

YES  NO

4. Have you ever been diagnosed with an irregular heart rhythm?

YES  NO

5. Do you suffer from the skin condition psoriasis?

YES  NO

6. Are you currently taking anticoagulants, i.e. Warfarin?

YES

NO

**Patient's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**(Parent if under 16 years)**