Family Doctor Please Read

Dear Doctor

Thank you for seeing this volunteer, who is going on an international volunteering or gap year placement overseas - usually for 6-12 months, sometimes in countries with limited access to reliable medical facilities.

As you would imagine, overseas volunteer postings may result in increased physical and mental stress. The medical information provided in this form is used to assist the placement organization, find the most suitable placement for each individual. It is not a question of pass or fail, but of highlighting any areas where local support may be necessary. The volunteer will complete pages 1 to 8 prior to their appointment with you.

It would be appreciated if you could:

- ❑ **Review pages 1-8 and and provide details,** particularly with a view to whether this issue could cause difficulties while overseas. Eg if volunteer ticks history of broken bones – please note what bones, if this is healed with or without sequelae etc. If ticks headache, give details and note if this is significant or not.

- ❑ Encourage all volunteers to have had **a dental check** within the last 12 months, if this is not the case.

- ❑ **Review all vaccines** as per records provided, and complete as necessary. We recommend all volunteers be up to date with all routine immunisations. Other vaccines may be recommended once destination is confirmed.

- ❑ **Complete pages 8-10** of the attached medical review. Please comment on any issues that you think may be of importance, or may need special allowance made.
  Page 10 may be provided to the host country organisers to assist them cater to the needs of the participant.

- ❑ **Return entire form to the volunteer**.

Thank you for your assistance. Please email or call with any queries.

Yours faithfully,

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Dr Deb's TRAVEL MEDICINE CENTRES + WITH YOU EVERYWHERE
THE TRAVEL DOCTOR

SCREENING QUESTIONNAIRE

Date of Completion

DD98d

VOLUNTEER TO READ AND COMPLETE PLEASE

The primary purpose of this questionnaire is not to pass or fail. It is to anticipate any potential medical issues which may occur so that appropriate measures may be taken to lower your risk and increase your chance of a successful placement. A summary of this information may be required by placement organiser or the agency responsible for your medical care while overseas. No information will be sent without your signed consent for release, which follows at the end. You can withdraw consent at any time in writing. **It is most important that you, the volunteer, complete this form yourself.**

Your Details (PLEASE USE BLOCK LETTERS/PRINT NEATLY)

First Name | Last Name

Date of Birth | M/F | Start date of placement

Placement country and region if known | Estimated length of placement

Home Address

Phone (daytime) | Email Address

Overseas Position Involves

Brief description of duties overseas.....

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Cardiovascular (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ palpitations
- ☐ high blood pressure
- ☐ raised cholesterol
- ☐ ankle swelling
- ☐ chest pain
- ☐ anaemia
- ☐ other (specify).....
- ☐ heart attack
- ☐ valve problem
- ☐ heart surgery
- ☐ DVT (thrombosis)
- ☐ heart murmur
- **NONE OF THESE** ..... ☐

(Doctor please add details)

Respiratory (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ asthma
- ☐ emphysema
- ☐ tuberculosis
- ☐ shortness of breath
- ☐ pneumonia
- ☐ collapsed lung/pneumothorax
- ☐ other (specify).....
- ☐ pleurisy
- ☐ bronchiectatis/bronchitis
- ☐ coughing blood
- ☐ tendency to chest infections
- ☐ pulmonary embolism
- **NONE OF THESE** ..... ☐

(Doctor please add details)

if yes to Asthma
What age were you first diagnosed with asthma? .....

How many days off work or school have you had due to asthma in the last 2 years?.....

Are there any known triggers for your asthma? If yes, please list:

.....

Gastrointestinal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ stomach ulcer
- ☐ gall stones
- ☐ unexplained weight loss
- ☐ hepatitis/jaundice
- ☐ haemorrhoids/piles
- ☐ indigestion
- ☐ abdominal pain
- ☐ irritable bowel syndrome
- ☐ hiatus hernia
- ☐ blood in motions
- ☐ frequent nausea, vomiting/vomit blood
- ☐ endoscopy
- ☐ colonoscopy
- ☐ ulcerative colitis/ crohn's disease
- ☐ pancreatitis
- ☐ **NONE OF THESE** .....
- ☐ other (specify) .....

(Doctor please add details)

Neurological/Psychological (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ depression
- ☐ anxiety/phobias/compulsions
- ☐ counselling
- ☐ panic attacks
- ☐ epilepsy/fits
- ☐ headaches/migraine
- ☐ deafness
- ☐ insomnia
- ☐ fainting
- ☐ paralysis/stroke
- ☐ referred to or seen a psychiatrist/psychologist
- ☐ head injury/concussion
- ☐ tingling/numbness/pain
- ☐ post traumatic stress disorder
- ☐ **NONE OF THESE** .....
- ☐ other (specify).....

(Doctor please add details)

Psychological

(Doctor please add details)

During the past month:

Have you felt feeling down, depressed or hopeless? ☐ y ☐ n

Have you felt little interest or pleasure doing things? ☐ y ☐ n

What percentage of the time do you expect this placements will be fun ..... %

What is the primary reason for undertaking this placement?

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Overseas placement can be demanding and problems with adjustment to culture, travel, separation from family etc can sometimes occur. Do you have any partical concerns regarding your ability to adjust to these demands? ☐ y ☐ n

Comments .....

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Musculoskeletal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ arthritis
- ☐ broken bones/sprains
- ☐ muscle weakness
- ☐ repetitive strain injury (RSI)
- ☐ other (specify) .....
- ☐ back or neck pain
- ☐ joint surgery
- ☐ **NONE OF THESE** .....

(Doctor please add details)

Skin (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ psoriasis
- ☐ skin cancers
- ☐ herpes
- ☐ eczema/dermatitis
- ☐ other skin problems (specify)

.....

- ☐ wounds failing to heal
- ☐ recurrent boils
- **NONE OF THESE** ..... ☐

(Doctor please add details)

When outdoors, how often do you do the following?	Always	Sometimes	Rarely
Wear a hat			
Wear sunglasses			
Apply sunscreen beforehand			
Wear protective clothing			

Genito-urinary (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ chlamydia
- ☐ kidney stones
- ☐ bladder problems
- ☐ blood in the urine
- ☐ urinary tract infection
- ☐ other kidney or urinary problems (specify) .....

.....

.....

- ☐ sexually transmitted diseases
- ☐ lose urine when cough or laugh
- **NONE OF THESE** ..... ☐

(Doctor please add details)

Men only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ testicular problems
- ☐ prostate problems
- ☐ hernia
- ☐ other (specify) .....

- ☐ significant change in urinary flow
- **NONE OF THESE** ..... ☐

(Doctor please add details)

Women only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ irregular periods
- ☐ heavy periods
- ☐ periods stopped
- ☐ other gynaecological problem .....

- ☐ breast lumps
- ☐ prone to vaginal thrush
- ☐ pregnant or planning
- **NONE OF THESE** ..... ☐

(Doctor please add details)

Other (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ diabetes – on insulin (_)
  – on tablets (_)
  – diet controlled (_)
- ☐ immune weakness
- ☐ cancer of any sort

- ☐ thyroid problem
- ☐ chronic fatigue
- ☐ clotting problems
- ☐ Thrombosis or DVT
- **NONE OF THESE** ..... ☐

(Doctor please add details)

Glasses (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

Do you wear glasses? y n

Do you wear contact lenses? y n

Is your last optometrist or eye specialist review over 12 months ago? y n

(Doctor please add details)

Dental (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

Is it more than 12 months since your last dental check? y n

If your last dental check was more than 12 months ago, you are strongly encouraged to have a checkup prior to departure. Dental abscesses are very painful and emergency dental treatment while overseas is inconvenient, expensive and not always safe.

(Doctor please add details)

Diet and Weight

Are you currently following, or planning to start, a special type of diet or a restricted diet? y n

(Doctor please add details)

If yes

Vegetarian y n

No Red Meat y n

Other (please describe).....

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Have you ever been told you have an eating disorder (anorexia, bulimia)? y n

Exercise

(Doctor please add details)

Please tick which type of exercise do you do in a typical week?

- ☐ No regular exercise
- ☐ Jogging
- ☐ Brisk walking
- ☐ Gymnasium workout
- ☐ Other (state) .....

Average session is ____ minutes ____ times per week

EPWORTH SLEEPINESS SCALE

Scale: 0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3

TOTAL SCORE:

EPWORTH SCORE

Score	*Rating*
0 – 9	Normal
> 10	Need sleep review

Smoking

Have you ever smoked tobacco? y n

(Doctor please add details)

If yes, which best describes your smoking history?

- ☐ Never smoked regularly
- ☐ Current average ____ cigs per day from age ____ yr

Alcohol & Recreational Drugs

Please estimate your average weekly alcohol consumption in standard units.

1 unit = 30ml measure of spirits 120ml glass of wine
285ml glass of beer 60ml glass of sherry

(Doctor please add details)

Estimates total units per average week ____ units.

How many alcohol free days do you have per week ____ d

How often do you have six or more drinks on one occasion?

- ☐ Never
- ☐ Monthly or less
- ☐ Weekly
- ☐ Daily or almost daily

In the last 12 months have you used Marihuana or other recreational drugs? y n

Your Name (full name)

Medications

Do you take any medications? y n

(Doctor please add details)

If yes, please list any prescription and non-prescription medication which you use regularly or as required. Include inhalers, patches, laxatives, fluid tablets, weightloss medication, prescription creams, vitamins and 'quit smoking' medication.

NAME: DOSE:

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Allergies

(Tick more than one if applicable)

(Doctor please add details)

Do you have any known allergies? y n

- ☐ I get hayfever/eczema/asthma
- ☐ I am allergic to .....
- ☐ I have a serious or life threatening allergy to

  .....
- ☐ I have previously required adrenaline (Epinephrine/Epipen) or hospitalisation for an allergic reaction
- ☐ I carry adrenaline (eg Epipen) when travelling

Illness/Injuries/Surgery

(Doctor please add details)

Have you ever had surgery to remove any body parts? y n

If yes please tick:

☐ tonsils ☐ appendix ☐ spleen ☐ breast

☐ other *(please name)* .....

Have you been absent from work or school in the last 5 years for more than a week due to illness, injury or a surgical operation? y n

If yes please outline .....

.....

.....

.....

Have you been referred to a specialist in the last 5 years?

If yes please outline .....

.....

YOU WILL NEED TO ATTACH A REPORT FROM YOUR SPECIALIST/ TREATING PRACTITIONER OR YOUR MEDICAL CANNOT BE PROCESSED

Screening Tests

(Doctor please add details)

Have you had a skin cancer check? y n

If Yes when: m yr

- ☐ Normal
- ☐ Abnormal (please state) .....

Have you had a test for HIV AIDS in the last 5 years? y n

If yes, result: .....

Vaccine History

Childhood Vaccine Records

Fill in the dates of the various doses or blood tests and tick each disease if complete

Complete ?

POLIO – *at least 3 doses*

y n

Dose 1	Dose 2	Dose 3

TETANUS – *at least 4 doses and last dose must be within 10 years*

y n

Dose 1	Dose 2	Dose 3	Dose 4

MMR (Measles, Mumps Rubella) – *2 doses or confirmed serology*

y n

Dose 1	Dose 2	or	Blood test

CHICKENPOX/VARICELLA – *2 doses or confirmed serology*

y n

Dose 1	Dose 2	or	Blood test

HEPATITIS B – *3 doses. (If given age 11-15 need only 2 doses 6 months apart)*

y n

Dose 1	Dose 2	Dose 3

Family History

Do you have a parent or sibling with any of the following?

- ☐ Male heart disease below age 55
- ☐ Female heart disease below age 65
- ☐ DVT/Thrombosis/Lung embolism
- ☐ Stroke
- ☐ Bowel Cancer
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Schizophrenia/Mania/Depression
- ☐ Alcohol problem
- ☐ Other health problems that run in the family

Comments .....

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..... **NONE OF THE ABOVE** ☐

(Doctor please add details)

Other Concerns

Do you have concerns regarding any problems we have not asked about or other health issues which might occur while you are away? (If so, the doctor will discuss these with you). y n

If Yes (please state).....

.....

.....

(Doctor please add details)

Your Name (full name)

WE NEED TO SEE A REPORT FROM ANY SPECIALIST YOU HAVE SEEN WITHIN THE PREVIOUS 5 YEARS.

PLEASE ENSURE YOUR NAME IS COMPLETED AT THE TOP OF EACH PAGE.

HONESTY – PLEASE READ THIS CAREFULLY

If you know you have **not** included something you find difficult, or you think might be considered unacceptable, please consider the following carefully.

Anything you have omitted could be the issue with the potential to cause you difficulty in a stressful assignment in the field. Remember being honest about your medical status boosts your capacity to perform well in the field. It helps your placement organisation provide the right posting and support network. It protects your colleagues from extra burdens. It safeguards the quality of the work you can deliver. Ultimately it helps the people you are going to serve.

AUTHORITY TO RELEASE RESULTS

I understand the importance of being honest in my responses on this form and I have completed the above information correctly to the best of my knowledge and recollection. I understand this medical assessment is for the purpose of identifying potential health problems during my placement. I authorise the examining doctor to release this report in part or in full, by confidential fax, email or post, together with relevant pathology results or reports if required to: potential host organisations and its nominated medical advisors: Dr Deb the Travel Doctor.

Signature

/ /20

Witness

/ /20

THANK YOU

PHYSICAL EXAMINATION

Name

Date of Birth ☐ M ☐ F

Date of Medical

DD98d

Proof of identity produced? (y) (n) ☐ Passport ☐ Drivers Licence ☐ Known to Doctor

Body Habitus

(Doctor please add details)

Height cm Weight kg

Body Mass Index kg/m²

Person with raised BMI are at increased risk of difficulties with mobility and may have increased risk of injury. They may need assistance with dietary issues. I strongly recommend influenza vaccine for all candidates over BMI 30 due to increased risk of hospitalisation from influenza.

Are there any operation scars? (y) (n)

Are there any abnormal skin lesions? (eg dysplastic naevi etc) (y) (n)

Are there any identifying marks (tatoos/scars)? (y) (n)

Facial hair? (y) (n)

Is there any lymphadenopathy? (y) (n)

Cardiovascular System

(Doctor please add details)

Blood pressure readings
If over 140/90 please provide 2 further readings at 5 minute intervals.

Resting	1	2	3
Systolic			
Diastolic			

Pulse rate ____ per minute

Are there any varicose veins? (y) (n)

Is there any abnormality of the pulse? (y) (n)

Is there any abnormality of the heart sounds? (y) (n)

Is there a heart murmur? (y) (n)

Respiratory System

(Doctor please add details)

Is the trachea displaced? (y) (n)

Are the breath sounds abnormal? (y) (n)

Are there any added sounds? (y) (n)

Is spirometry abnormal? (asthma, smoker or other indication) (nd) (y) (n)

Alimentary System

(Doctor please add details)

Are there any abnormalities of the teeth, gums or oropharynx? (y) (n)

Is there any abnormal tenderness or organomegaly? (y) (n)

Other abnormality? (please specify) .....

Urine Analysis

(Doctor please add details)

Blood ____ Glucose ____ Protein ____

(We strongly encourage all volunteers to have a urine 'dip' test)

Central Nervous System

(Doctor please add details)

Are there any abnormalities of the auditory canals or ear drums? y n

Are the pupils abnormal? y n

Is there any abnormality in: tone, power, co-ordination, sensation? y

Are the reflexes abnormal? y n

Are there any tremors? y n

Is there any evidence of colour blindness? y n

Visual acuity (without correction) R 6/ L 6/

(with correction) R 6/ L 6/

Does audiometry show significant hearing loss? y n
(Renne/Weber test with tuning fork or whisper test is sufficient)

Musculo-Skeletal

(Doctor please add details)

Is there a limp or abnormality of gait? y n

Is there any restriction of movement or pain in neck, back or limb joints? y n

Is there any evidence of joint surgery? y n

Would the applicant have any difficulty running? y n

Would the applicant have any difficulty squatting? y n

Would the applicant have any difficulty climbing stairs? y n

Would the applicant have any difficulty climbing ladders? y n

Would the applicant have difficulty sitting on the floor for prolonged periods? y n

Further Tests and Investigations

(Doctor please add details)

Are any further investigations required? y n

Is medical specialist opinion required? y n

Would you recommend a dental opinion? y n

Are specialist/counsellor etc reports attached? y n

Please list:

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Your Name (full name)

Summary Page

In your medical opinion are there any medical conditions that will need ongoing management over the next twelve months.

Condition	Routine Management
eg: Asthma	Regular Ventolin
.....	.....
.....	.....
.....	.....

Are there any other special needs or medical requirements that this volunteer may require during their placement if a known condition was to deteriorate.

Condition	Special need or Medical Management or Consideration
eg. Asthma	Attack requiring Prednisone 50mg daily for 3days
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Name of Medical Examiner

CHECKLIST BEFORE SENDING

- ☐ Doctors note re any positive history
- ☐ All sections complete.
- ☐ Specialist reports attached if any.

Doctors Signature

Date of Medical Examination

CLINIC DETAILS

Clinic Name: .....

Address: .....

Phone: ..... Fax: .....

Email: .....