



# MALARIA PROPHYLAXIS SCREENING FORM

*This document is intended as part of a screening process to determine if you will need medications to prevent MALARIA. It will also be used to determine if it is safe for you to take these medications. Please complete this form to the best of your ability and sign the document.*

## Determination of risk

1. Will you be visiting any of the following locations: (Please circle the location(s))	YES	NO
<p><b>Africa:</b> Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Egypt, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Libya, Madagascar, Malawi, Mali, Mauritius, Mauritania, Morocco, Namibia, Niger, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, Somalia, South Africa, Sudan (south of 15° N), Tanzania, Togo, Tunisia, Uganda, Yemen, and Zambia.</p> <p><b>Americas:</b> Argentina (Rural areas), Belize, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, French Guiana, Guatemala, Guyana, Honduras, Nicaragua, Panama (not to include the Panama Canal zone), Peru, Suriname, and Venezuela.</p> <p><b>Asia:</b> Afghanistan, Azerbaijan (lowlands), Bangladesh, Bhutan, Burkina Faso, Burma, Cambodia, China (Rural areas), , Djibouti, Egypt (El Faiyûm area only), India, Indonesia, Kyrgyzstan, Laos, Malaysia, Pakistan, Papua New Guinea, Philippines, Sri Lanka, South Korea, Syria, Thailand, Turkey, Viet Nam,</p> <p><b>Caribbean:</b> Dominican Republic, Haiti, Trinidad and Tobago.</p> <p><b>Other Locations:</b> please list:</p>		
2. Will your vessel be within 1 mile from the shoreline of any of the above locations?		
3. Will you leave the vessel to go ashore at any of the above locations?		

## Medical History

Please complete this section of the document. If you have any questions regarding this document please consult your medical provider or the staff at COMBI. Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer YES. If any of these items apply to you, we might request that you consult with a physician prior to participating in malaria prophylaxis.

	YES	NO		YES	NO
Could you be pregnant, or are you attempting to become pregnant?			Do you have, or have you ever been treated for a heart condition; including		
Are you presently taking prescription medications?			Heart attack		
Do you have any history of nerve, muscle or nervous system disorders including:			Coronary artery disease/angina		
Seizures or epilepsy, blacking out			Blood vessel disease		
Parkinson's, tremors or decreased muscle control			Chest pain		
Do you have, or have you been treated for psychiatric disorders including:			Do you have, or have you ever been treated for blood diseases or disorders, including:		
Depression, bipolar disorder or anxiety			Sickle cell anemia		
Claustrophobia			Anemia		
Psychosis or hallucinations			Malaria		
Do you have any history or, or been treated for any heart, blood or blood vessel conditions including:			Do you have, or have you ever been treated for a digestive disorder, including:		
Heart attack or angina			Gastritis, reflux		
High blood pressure			Peptic ulcer disease, ulcers		
Heart valve disease			Diverticulitis, colitis		
Sickle cell anemia			Blood in your stool or vomit		
Inability to perform moderate exercise (example: walk one mile in 12 mins)?			Have you had any major surgeries?		
High Cholesterol levels			Has your health changed recently?		
Do you have, or have you ever been treated for a lung condition or disease, including the following:			Are you allergic to any medications?		
Pneumonia			Have you ever been diagnosed or treated for malaria?		
Chronic Bronchitis/emphysema			Have you ever received medications to prevent getting malaria?		
Asthma			If yes to above, did you have any reaction to the medications?		
Other lung disease or lung conditions					

Name: \_\_\_\_\_ Vessel \_\_\_\_\_

Please list any major surgeries you have had: \_\_\_\_\_

Please list any medications you are currently taking (prescription/over the counter/ herbals): \_\_\_\_\_

Please list any allergies to any medications you might have: \_\_\_\_\_

The information I have provided about my medical history is accurate to the best of my knowledge. *I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition. I have read the malaria prevention information provided to me, and I understand the potential risks and benefits of taking medications to prevent contracting malaria.*

*I further understand that taking malaria medications is not a guarantee that I will not contract malaria.*

*With this information in mind, I*

( ) *Request malaria prophylaxis/prevention*

( ) *Decline malaria prophylaxis/prevention*

\_\_\_\_\_  
*Name (Please Print)*

\_\_\_\_\_  
*Vessel*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

#### PHYSICIAN'S STATEMENT

( ) In reviewing the exposure risk for this individual and their medical history, I feel that:

1. The benefit of malaria chemoprophylaxis out weights the risk; and
2. There are no strong medical contraindications to malaria prophylaxis, and
3. The following medication regimen for malaria prophylaxis is prescribed for dispensing and administration to the above name individual:
  - a. \_\_\_\_\_ Atovaquone/proguanil 250 mg/100 mg po qd 2 days before exposure and then until 7 days after exposure.
  - b. \_\_\_\_\_ Doxycycline: 100 mg po qd 2 days before exposure until 4 weeks after exposure.
  - c. \_\_\_\_\_ Mefloquine: 250 mg po qd every 7 days beginning prior to exposure and continuing until 4 weeks after exposure
  - d. \_\_\_\_\_ Chloroquine: 500 mg qd every 7 days beginning prior to exposure and continuing until 4 weeks after exposure.

( ) In reviewing the potential exposure risk for this individual and their medical history, I feel that malaria chemo-prophylaxis is not warranted.

\_\_\_\_\_  
Bruce K. Bohnker MD MPH  
Medical Director – United Maritime Shipping

\_\_\_\_\_  
Date

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