

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(mo.) (day) (yr.)

# Screening Checklist for Contraindications to Vaccines for Adults

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your immunization record card with you?**    yes     no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.