Screening Questionnaire for Immunizations

- It is important for you to keep a record of your vaccinations. If you don't have a record, ask your health care provider to give you one. **Bring your shot record every time you seek medical care.**
- You should stay in the health department for 15-20 minutes after receiving vaccines.

Patient Name: ________________________________ Date of Birth: _____/_____/_____
(mo.) (day) (yr.)

For Patients: *The following questions will help us determine which vaccines may be given today. Please ✓ the appropriate answer. If a question is not clear, please ask your health care provider to explain it.*

Questions	Yes	No	Don't know
1. Have you had a fever or been sick recently?			
2. Do you have any allergies to medication or food? Circle any that apply: eggs, yeast, thimerisol, neomycin, streptomycin, sulfa drugs, epinephrine or benadryl. List any others ______________________			
3. Have you ever had an allergic or other serious reaction after receiving any vaccinations?			
4. Do you, or anyone in your home, have cancer, leukemia, AIDS, or any other immune system problem?			
5. Do you take cortisone, prednisone, other steroids or anticancer drugs or have you had radiation treatments?			
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
7. Are you pregnant or is there a chance you could become pregnant in the next 3 months? LMP ______________________			
8. Have you received any vaccinations in the past 4 weeks?			
9. Have you ever had a seizure/convulsion; psychiatric disturbance or nerve/brain disorder?			
10. Do you have any serious health problems? If yes, please list ______________________			
11. Are you currently taking any medication? If yes, please list ______________________			
12. Did you bring your immunization record with you?			

❑ CLIENT QUESTIONNAIRE REVIEWED ______________________________
PHN SIGNATURE

PHYSICIAN'S NOTE ONLY

❑ CLIENT QUESTIONNAIRE REVIEWED ______________________________
PHYSICIAN'S SIGNATURE