**Patient Name: _____ Date of birth: _____/_____/_____**

# 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? | ☐ | ☐ | ☐ |
| 2. | Do you have allergies to medicine, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| 3. | Have you ever had a serious reaction after receiving a vaccine? | ☐ | ☐ | ☐ |
| 4. | Do you have any of the following: a long – term health problem with heart, lung, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? | ☐ | ☐ | ☐ |
| 5. | Are you on long – term aspirin therapy? | ☐ | ☐ | ☐ |
| 6. | Do have cancer, leukemia, HIV/AIDS, or any other immune system problems? | ☐ | ☐ | ☐ |
| 7. | Do you have a parent, brother, or sister with an immune system problem? | ☐ | ☐ | ☐ |
| 8. | In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? | ☐ | ☐ | ☐ |
| 9. | Have you had a seizure or a brain or other nervous system problem? | ☐ | ☐ | ☐ |
| 10. | Have you been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syendrome (MIS-C) after an infection with the virus that causes COVID-19? | ☐ | ☐ | ☐ |
| 11. | In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| 12. | **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? | ☐ | ☐ | ☐ |
| 13. | Have you received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |
| 14. | *If receiving influenza vaccine, please ask this additional question:* Are you employed in the agriculture industry such as dairy producers, poultry workers, milk processing plant employees, or other animal agriculture? | ☐ | ☐ | ☐ |

**Form completed by: _____ Date: _____**

**Form reviewed by: _____ Date: _____**

**Did you bring your immunization records with you? Yes ☐ No ☐**

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

**FHD-CL-IMM-2** Acquired from http://www.immunize.org. We thank the Immunization Action Coalition

Rev: 12/7/2018, 8/29/2024