Screening Questionnaire Immunizations

NAME_____**Date of Birth:** _____

☐ Hepatitis A	☐ Hepatitis B	☐ Japanese Encephalitis	☐ Menomune (MPSV) SQ
☐ IM Menactra Vaccine (MCV4)	☐ MMR	☐ Rabies	☐ Polio ☐ Td
☐ TDap	☐ Twinrix	☐ Typhoid	☐ Varicella
☐ Yellow Fever			

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, 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.

NOT FOR EXTERNAL RELEASE

	Date
1. Are you sick today?	No
2. Do you have allergies to medications, food, eggs, yeast, latex, vaccines or vaccine preservative such as Thimerosal? Circle which.	No
3. Have you ever had a serious reaction after receiving a vaccination?	No
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 disorder?	No
5. Do you have any conditions that may compromise your immune system?	No
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? ***** > 25mg a day – vaccines not recommended.**	No
7. Have you had a seizure, brain, or nerve problem?	No
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	No
9. Have you received any vaccinations in the past 4 weeks?	No
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month? **If Pregnant indicate how many weeks gestation**_____**.**	No
11. Do you have any medical condition not listed, that we should be aware of?	No
12. Please List ALL MEDICATIONS.	**Patient Initials** _____

Corporate Health Signature: _____ Date: _____

I have read or had explained to me the information on this form about the requested vaccine(s). I have had a chance to ask questions and have them answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and that it be given to me.

Patient Signature: _____ Date: _____