Screening Questionnaire for Immunizations

Patient Name: _____ Date of Birth: _____ Age: _____

- 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.

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. Did you bring your immunization record with you?			
2. Are you sick today?			
3. Do you have any allergies to medication or food? Circle any that apply: eggs, yeast, gelatin, Thimerosal, latex, neomycin, streptomycin, sulfa drugs, Epinephrine or Benadryl. List any others, including allergy to any vaccine component: _____			
4. Have you ever had an allergic or other serious reaction after receiving any Vaccinations, including the influenza vaccine?			
5. In the past three 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?			
6. Do you have a history of intussusception (portion of the bowel slides into another portion of the bowel)?			
7. Do you have a history of Guillain-Barre Syndrome (GBS, an autoimmune condition causing temporary muscle weakness)?			
8. Are you pregnant or is there a chance you could become pregnant in the next month? First day of last menstrual period _____ **Many vaccines should not be given to women known to be pregnant and pregnancy should be avoided for 4 weeks following receipt of a live virus vaccine.*			
9. Have you received any vaccinations in the past 4 weeks?			
10. Have you ever had a seizure/convulsion, anxiety, depression, psychosis, or any other major psychiatric disturbance or nerve/brain disorder?			
11. Do you have any serious health problems such as heart disease, arrhythmia or heart murmur, kidney disease or anemia, or a neurologic or neuromuscular disorder that may cause breathing or swallowing problems to include asthma? If yes, please list _____			
12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or any antiviral drug? _____			
13. Are you currently taking any prescription medications or over-the-counter medications to include daily long-term aspirin and aspirin containing therapy?			
14. Are you taking any prescription medication to prevent or treat flu?			

CLIENT QUESTIONNAIRE REVIEWED BY:

_____ _____

PHN SIGNATURE *PHYSICIAN'S SIGNATURE*

NOTES: _____

_____