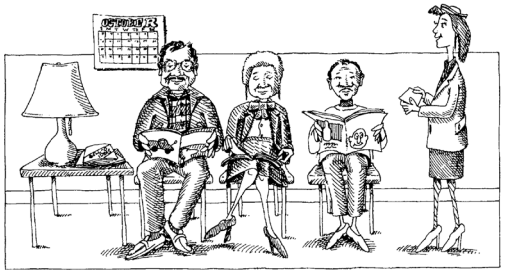
Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



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.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
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?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

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.

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