Screening Questionnaire for Adult Immunization

Legal Name: (Print) _____ **Phone Number:** _____

Mailing Address: _____ **City:** _____ **Zip Code:** _____

Date of Birth: _____ **Gender:** ☐ **M** ☐ **F** **Mother's First Name:** _____

For patients: Questions 1-9 below will help us determine which vaccines you may be given today. If a question is not clear, please ask your nurse to explain it.

	Yes	No
1. Are you sick today?	.....	.....
2. Do you have allergies to medications, food (eggs, gelatin), or latex or a vaccine component? Please explain: _____	.....	
3. Have you ever had a serious reaction after receiving a vaccination?	.....	.....
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	.....	.....
5. In the past 3 months, have you taken prednisone, steroids, or drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis, or anticancer drugs, or have you had radiation treatments?	.....	.....
6. Have you had a history of seizures or other nervous system problems?	.....	.....
7. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral medication?	.....	.....
8. **Women**: Are you pregnant or is there a chance you could become pregnant during the next month?	.....	.....
9. Have you received any vaccinations in the past 4 weeks?	.....	.....
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?	.....	.....

To receive FluMist answer the following questions also.

11. Is the person to be vaccinated younger than age 2 or older than age 49 years?	.....	.....
12. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic disease, liver disease, disease (e.g. diabetes), or anemia or another blood disorder?	.....	.....
13. Does the person to be vaccinated have wheezing or asthma?	.....	.....
14. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	.....	.....

Signature: _____ **Today's Date:** _____

For Staff Use Only: Next to each vaccine received please add injection site:

Administer By: _____

CAIR: _____ **P/C** _____

☐ **PRIVATE** ☐ **STATE**

☐ **317**
- ☐ Uninsured
- ☐ Underinsured (insurance doesn't cover vaccines, or certain vaccines, or fixed dollar limit has been reached)

Tdap P 317 **Lot#**	**Td**	**MMR Var Lot#**	**Hep A** P 317 **Lot #**	**Hep B** P 317 **Lot #**	**Twinrix**	**Pneumo** PCV13 PPSV	**Flu** IIV LAIV	**Other**	**Other**
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