SCREENING QUESTIONNAIRE FOR CHILD/ADOLESCENT IMMUNIZATION ADMINISTRATION

PATIENT NAME: _____ DATE OF BIRTH: _____

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 may be asked. If a question is not clear, please ask and we will explain it to you.	YES	NO	DON'T KNOW
Are you [the patient] sick today?			
Do you [the patient] have any allergies to medications, food, or any vaccine? If yes, please list: _____			
Have you [the patient] ever had a serious reaction after receiving a vaccination? If yes, please explain: _____			
Do you [the patient] have cancer, leukemia, AIDS, or any other immune system problem? If yes, please list: _____			
Have you [the patient] taken cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments in the last 3 months?			
Do you [the patient] have a seizure, brain, or nerve problem? If yes, please explain: _____			
During the past year, have you [the patient] received a transfusion of blood or blood products, or been given a medicine called immune [gamma] globulin?			
Have you [the patient] received any vaccinations in the past 4 weeks?			
For Women: Are you pregnant or is there a chance you could become pregnant during the next month?			
Any reason you should not get a shot in a particular arm? Like you had a mastectomy or any lymph node removal burns graft, etc? If yes, please explain [indicate left or right side]: _____			
Did you bring your immunization shot record/card with you today?			

How did you hear about us?: _____

Would you like an email reminder for follow-up appointment(s)? _____

If Yes, please list email address: _____

FORM COMPLETED BY: _____ DATE: _____

The Immunization Clinic

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