Patient Name: ______________________ Date of Birth: ___/___/___
(MM/DD/YYYY)

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 us to explain it. Thank you.**

		Circle One		
1.	**Are you sick today?**	**Yes**	**No**	**Not Sure**
2.	**Do you have allergies to medications, food, a vaccine component, or latex? If so, which? ______**	**Yes**	**No**	**Not Sure**
3.	**Have you ever had a serious reaction after receiving a vaccination? If so, explain. ______**	**Yes**	**No**	**Not Sure**
4.	**Do you have long-term problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. Diabetes), anemia or other blood disorder?**	**Yes**	**No**	**Not Sure**
5.	**Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?**	**Yes**	**No**	**Not Sure**
6.	**In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatment?**	**Yes**	**No**	**Not Sure**
7.	**Have you had a seizure or a brain or other nervous system problem?**	**Yes**	**No**	**Not Sure**
8.	**During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?**	**Yes**	**No**	**Not Sure**
9.	**For women: Are you pregnant or is there a chance you could become pregnant during the next month?**	**Yes**	**No**	**Not Sure**
10.	**Have you received any vaccinations in the past 4 weeks?**	**Yes**	**No**	**Not Sure**

Please Sign:

Form Completed by: ______________________ **Date:** ______________

Form Reviewed by: ______________________ **Date:** ______________

Did you bring your immunization records with you? Yes No

It is important to have a personal record of your vaccinations. If you don't have a personal record, please 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.

Thank you.