**Immunization Questionnaire**

The following question will help us determine which vaccines you or your child 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 your healthcare provider for explanation.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_M \_\_\_\_\_\_\_F

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous serious vaccine reactions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete section I. if receiving vaccination for any of the following: Diphtheria, Tetanus, Pertussis, Polio, Hepatitis A, Hepatitis B, Haemophilus Influenza type b, Human Papilloma Virus, Meningococcal, Measles, Mumps, Rubella, Pneumococcal, Rotavirus, Varicella/Chickenpox and/or Zoster/ Shingles**

1. **Is/has the person who is receiving the immunization:**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Y= Yes N=No ?= Unsure** | **Y** | **N** | **?** |
| 1. **Sick today or have/had an illness with fever within the last twenty-four hours?**
 |  |  |  |
| 1. **Had any vaccines in the past 30 days?**

**(if live vaccine given in past 30 days: MMR, Varicella, LAIV, Zoster)** |  |  |  |
| 1. **Ever had a serious reaction after receiving a vaccination?**
 |  |  |  |
| 1. **Ever had Guillan-Barre Sydrome?**

**(If within 6 weeks after a previous dose of tetanus toxoid-containing vaccine – Dtap, Tdap if within 6 weeks after a previous dose of influenza vaccine- TIV, LAIV)** |  |  |  |
| 1. **Allergic to chicken eggs? (anaphylactic reaction: hives, swelling of mouth and throat, difficulty breathing)**

**(TIV, LAIV)** |  |  |  |
| 1. **Allergic to Yeast (anaphylactic reaction: hives, swelling of mouth and throat, difficulty breathing)**

**(Hep B, HPV)** |  |  |  |
| 1. **Allergic to gelatin?**

 **(Varicella)** |  |  |  |
| 1. **Allergic to Streptomycin, Neomycin, or Polymixin B?**

**(MMR, IPV, Varicella, Zoster)** |  |  |  |
| 1. **Allergic to latex?**

**(Menactra)** |  |  |  |
| 1. **Allergic to Thimerisol?**

**(TIV)** |  |  |  |
| 1. **Taking cortison, prednisone, other steroids or anticancer drugs or have you had x-ray treatments?**

**(Live vaccines-MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **Have active tuberculosis?**

**(Live vaccines- MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **Have cancer, Leukemia, AIDS or any other immune system problems?**

**(Live Vaccines- MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **Have any long-term health problems with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, metabolic disease (e.g.) diabetes,) liver diease, enemia or other blood disorder?**

**(Live vaccines- MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **Have/had a seizure, convulsion, brain or other nervous system problem?**

**(DTap, Td or Tdap)** |  |  |  |
| 1. **During the past year have you received blood products, transfusion, plasma, organ or stem cell transplant or been given a medicine called immune (gamma) globulin?**

**(Live vaccines- MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **Living with or have close contact with someone who is being treated for cancer, has problems with his/her immunity or has another serious illness who must be in protective isolation?**

**(Live vaccine- MMR, Varicella, Zoster, LAIV)** |  |  |  |
| 1. **History of intussusception or severe combined immunodeficiency (SCID)?**

**(Rotavirus)** |  |  |  |
| 1. **Have you taken antiviral medication 24-48 hours before vaccination?**

**If yes; Delay resumption of antivirals for 14 days following vaccinations if possible.** * **Acyclovir, famciclovir or valacyclovir = Varicella, Zoster**
* **Amantadine, rimantadine, zanamivir or oseltamivir = LAIV**
 |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_