

Screening Checklist for Vaccination Adults

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 health care provider to explain it.

| | YES | NO | Unknown |
|--|--------------------------|--------------------------|--------------------------|
| 1. Do you have allergies to medications, food, a vaccine component, or latex? What are you allergic to? Please List: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had a serious reaction after receiving a vaccination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn’s disease, or psoriasis; or have you had radiation treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a seizure or a brain or other nervous system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you received any vaccinations in the past 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. COVID VACCINATION STATUS: Please give dates of vaccines and brand. _____

Did you have any vaccine reactions to the COVID vaccine? If so please explain:

Do you have ANY other concerns that you would like the doctor to be aware of **before** your first vaccination? If so, do you give our doctor permission to speak with your medical provider? You must let your provider know that she may be calling and your provider may need it in writing.

Please sign here to give us permission to request a phone call from your provider and any medical records that your provider deems necessary to share. _____

Providers name and contact information: _____

Form completed by _____ **Date:** _____