Screening Checklist for Contraindications to Vaccines for Adults

Patient Name: _____

Date of Birth: _____/_____/_____

For Patients The following question will help us determine which vaccines you may be given today. If you answer "yes" to any questions, 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 healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-tern health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the last 3 months, have you taken medications that affect your immune systems, 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?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problems?	☐	☐	☐
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?	☐	☐	☐
9. For the Woman: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Primary Care Provider: _____ Date: _____

Form Completed By: _____ Date: _____

Form Reviewed By: _____ Date: _____

Did You Bring your Immunization record card with you? Yes ☐ No ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, 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 health care provider records all your vaccinations on it

RX LABEL

Left Arm – O / Right Arm – O Lot # _____ / Exp# _____