Yellow Fever Vaccine Questionnaire

BRIGHTSIDE SPECIALTY PHARMACY
431 N Tustin Ave Ste C, Santa Ana CA 92705
(714) 707-5115

PLEASE PRINT IN BLACK INK

Patient Information:

Patient Name (exactly as it appears on passport): _____

Date of Birth: _____/_____/_____ Phone Number: _____ Gender (circle): **Male** or **Female**

Street Address: _____ City: _____ State: _____ Zip: _____

Mother's Maiden Name: _____ Mother's First Name: _____

(this information is used for the State vaccination registry)

Emergency Contact Information:

Name: _____ Relation: _____ Phone Number: _____

Primary Physician (name) : _____ City: _____ State: _____

Required: Please answer all the following questions regarding medical conditions and history:

1. Have you ever received a yellow fever vaccine before? ☐ Yes ☐ No

   If no, proceed to question 2, **If yes,** please answer the following questions:

   1a. What was the date of your last yellow fever vaccine: _____

   1b. Were you pregnant at the time of your last yellow fever vaccine? ☐ Yes ☐ No

   1c. Have you received a booster dose since then? ☐ Yes ☐ No

   1d. Have you received a hematopoietic stem cell transplant since your last yellow fever vaccine?

   ☐ Yes ☐ No

   1e. Are you HIV positive? ☐ Yes ☐ No

   1f. Did you have an allergic reaction to your previous yellow fever vaccine? ☐ Yes ☐ No

2. Have you received a vaccine in the past 30 days or are planning to receive a vaccine in the next 30 days?

   ☐ Yes ☐ No

   2a. If yes, which vaccines? _____

3. Are you severely allergic to eggs or any component of the yellow fever vaccine? ☐ Yes ☐ No
4. Have you ever had a reaction to any previous vaccinations? ☐ Yes ☐ No
5. Are you currently pregnant or planning to become pregnant? ☐ Yes ☐ No
6. Are you breastfeeding? ☐ Yes ☐ No
7. Have you been diagnosed with HIV? ☐ Yes ☐ No

   7a. If yes, are you considered currently symptomatic or have a CD4+ T-lymphocyte count of $<200/mm^3$?

   ☐ Yes ☐ No

8. Have you ever been diagnosed with a thymus disorder? (Including: myasthenia gravis, DiGeorge Syndrome, thymoma, or thymectomy): ☐ Yes ☐ No

9. Have you ever received an organ transplant? (Including: bone marrow transplants in the past 2 years or any solid organ transplant) ☐ Yes ☐ No

   8a. If yes, when did the transplant occur? _____

   8b. Are you still taking immunosuppressive drugs related to the transplant? ☐ Yes ☐ No

10. Have you ever been diagnosed with an immune deficiency or cancer? ☐ Yes ☐ No

    10a. If yes, are you currently on any immunosuppressive therapies? (This includes but is not limited to: alkylating agents, TNF- α inhibitors, interleukin blocking agents, monoclonal antibodies targeting immune cells, and long term (≥14 days), high dose, oral corticosteroids): ☐ Yes ☐ No

11. Have you currently or recently received radiation therapy? ☐ Yes ☐ No

12. Do you have any additional medical conditions not covered above? ☐ None

_____

_____

13. Please list all medications you are currently taking (including any over the counter medications or supplements): ☐ None

_____ _____

_____ _____

_____ Please request an additional sheet if needed

14. Please list any allergies or reactions to medications, food, vaccines, insects, etc: ☐ None

_____ _____

_____ _____

Please read and initial the below statements:

_____ **I understand that this request is for the yellow fever vaccine only, and that I should seek out a full travel consult for a complete set of recommendations for my trip** including malaria prophylaxis medications, necessary maintenance medications for the duration of my travels, and any other vaccinations or medications that might be indicated for the location(s) I am visiting.

_____ **I have read, or had explained to me, the most up-to-date Vaccine Information Statement per the CDC for the yellow fever vaccine and understand the risks and benefits. I have been provided an opportunity to ask questions and they were answered to my satisfaction. I wish to receive the vaccine and hereby give my consent to receive the vaccine and for the provider to communicate the administration of the vaccine to my primary care practitioner, who is listed above. I have read the posted copy of the Patient's Privacy Policy (a copy is available upon request).**

Signature of patient/guardian: _____ Date: _____

Print Name: _____