CustomPlus PHARMACY

Custom Compounding and Traditional Pharmacy Solutions

PATIENT INFORMATION

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ - _____ WORK PHONE ( ) _____ - _____

MALE ☐ FEMALE ☐ BIRTH DATE _____ / _____ / _____ HEIGHT _____ WEIGHT _____

BILLING INFORMATION

PRIMARY INSURANCE _____ POLICY ID NUMBER _____

PLEASE CIRCLE HMO PPO OTHER

RxBIN _____ RxPCN _____ RxGROUP _____

NAME OF INSURED _____ SSN _____

CUSTOMPLUS CLINICAL SERVICES - IMMUNIZATION QUESTIONNAIRE

(1) Have you ever had an anaphylactic reaction to an injection? Symptoms include: trouble breathing, swelling of the mouth, tongue or throat, or a fast heartbeat immediately after injection	YES ☐ NO ☐
(2) Have you (or the person) ever had a severe reaction to ANY vaccine, which required medical care?	YES ☐ NO ☐
(3) Are you (or the person) allergic to eggs, thimersol, bakers yeast, streptomycin or neomycin?	YES ☐ NO ☐
(4) Are you (or the person) sick today (fever, diarrhea, or vomiting)?	YES ☐ NO ☐
(5) Are you (or the person) being treated for, or living with a patient receiving, chemotherapy or radiation for cancer, a patient infected with HIV/AIDS, receiving immunosuppressant medications (i.e. steroids, organ transplant antirejection drugs) or being treated for other immune disorders?	YES ☐ NO ☐
(6) Have you (or the person) been under a doctor's care in the past year (for reasons beyond normal physicals and ailments)?	YES ☐ NO ☐
(7) Have you (or the person) ever been diagnosed with Guillain-Barre Syndrome?	YES ☐ NO ☐
(8) Have you (or the person) received immune globulin or a blood transfusion in the past 7 months?	YES ☐ NO ☐
(9) Are you (or the person) pregnant or planning pregnancy in the next 3 months?	YES ☐ NO ☐

I have read, or have had explained to me, information about the diseases and vaccines that I am voluntarily requesting to receive. I have had a chance to ask questions that were answered to my complete satisfaction. I believe I understand the benefits and risks of the vaccines cited and ask the vaccine(s) to be given to me. I understand that it is recommended that I stay at this location for 15 minutes after receiving the vaccine and I am hereby releasing CustomPlus Pharmacy if I choose not to do so.

Signed _____ Date _____