People's Drug Store Immunization Screening Questionnaire

Patient Information:

First Name:_____ Last Name:_____
Date of Birth_____ Gender: Male ☐ Female☐
Address_____ City:_____
State_____ Zip Code_____ Phone:_____
Primary Care Physician:_____

I would like to receive the following immunization:_____

Vaccine Screening:

The following questions will help us to determine which vaccines you are eligible to receive today.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? If yes, please list:_____	☐	☐	☐
3.Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. 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? If yes, please list:_____	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. 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?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
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 women: 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? If yes, please list:_____	☐	☐	☐

*I have received a copy of the vaccine information sheet (VIS) and I have read or have had a pharmacist explain to me the information about the vaccine receiving today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and the risks of the vaccine(s). I request this vaccine be given to me or to the person named above for whom I am authorized to make this request.

_____I will remain in People's Drug Store for 15 minutes following my vaccination for observation of an adverse reaction

Patient/Guardian Signature:_____Date:_____

For Pharmacist Use:
Lot#_____ Expiration Date:_____ site:_____
Administering Pharmacist Signature_____