CASPER/NATRONA COUNTY DISEASE PREVENTION
IMMUNIZATION SCREENING QUESTIONNAIRE FOR ADULTS

Client's Name: _____ Sex: _____ Birthdate: _____ Age: _____ Today's Date: _____
First Middle Last

Mailing Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Physician: _____

Do you live in Wyoming? Yes No

☐Native American

☐ Underinsured ☐Uninsured ☐ Medicaid ☐ Insured Insurance Name _____ Policy # _____

General for All Immunizations

1. Are you allergic to **any** medications? If yes, what?_____ ..... YES NO
2. Have you ever had a reaction to a vaccine or an allergy to eggs? ..... YES NO
3. Do you have a fever or illness at this time? ..... YES NO
4. Have you been diagnosed with a febrile illness? ..... YES NO
5. Are you on chemotherapy, radiation treatments or taking steroids? ..... YES NO
6. Are you receiving immunosuppressive therapy, including corticosteroids or have an immunosuppressive illness (HIV)? YES NO
7. Do you take anti-coagulants or have a blood clotting disorder? ..... YES NO
8. Do you have a blood disorder or malignancy? ..... YES NO
9. Do you have tuberculosis? ..... YES NO
10. Are you taking any medications? ..... YES NO
    If yes, what? _____ For? _____
11. Have you ever had a seizure or convulsion? ..... YES NO
12. If female, is there any chance you could be pregnant? ..... YES NO
13. If female, are you nursing a baby? ..... YES NO
14. If traveling, is medical care available in the country you are visiting? ..... YES NO
15. Have you ever had Chicken Pox? ..... YES NO

HEP B (Hepatitis B) **Suggested but patient refused** ☐

1. Have you ever had Hepatitis B disease? ..... YES NO
2. Are you allergic to yeast? ..... YES NO
3. Have you ever received any Hepatitis B vaccine? ..... YES NO

MMR (Measles, Mumps, and Rubella) **Suggested but patient refused** ☐

1. Do you have an allergy to neomycin or eggs? ..... YES NO
2. Have you received a blood transfusion or blood products, including immune globulin, within the last 3 months? ..... YES NO
3. Are you pregnant? ..... YES NO

GARDASIL **Suggested but patient refused** ☐

1. Have you had an allergic reaction to a previous dose of Gardasil? ..... YES NO
2. Are you planning to become pregnant in the next 6 months? ..... YES NO

Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, and Pertussis) **Suggested but patient refused** ☐

1. Have you had a Td vaccine within the last 10 years? ..... YES NO
2. Have you ever had a severe reaction to Td vaccine? ..... YES NO
3. Do you have a wound? ..... YES NO

HAV (Hepatitis A Vaccine) **Suggested but patient refused** ☐

1. Have you ever had a severe reaction to Hepatitis A vaccine? ..... YES NO
2. Have you ever had "infectious" hepatitis? ..... YES NO

Men (Menactra, Menomune) **Suggested but patient refused** ☐

1. Have you ever had a dose of meningitis vaccine? ..... YES NO
2. Have you had a reaction to a previous dose of meningitis vaccine? ..... YES NO
3. Have you had a history of Guillian-Barre Syndrome (Menactra)? ..... YES NO

IPV (Inactivated Polio Vaccine) **Suggested but patient refused** ☐

1. Do you have an allergy to streptomycin or neomycin? ..... YES NO

TYP-I (Typhoid) **Suggested but patient refused** ☐

1. Have you had a Typhoid vaccination within the last 5 years? ..... YES NO
2. Have you had a reaction to a previous dose of Typhoid vaccine? ..... YES NO

VAR (Chicken Pox) **Suggested but patient refused** ☐

1. Have you ever had chickenpox? ..... YES NO
2. Are you pregnant? ..... YES NO
3. Have you had a reaction to a previous dose of chickenpox vaccine? ..... YES NO
4. Do you have an allergy to neomycin? ..... YES NO
5. Do you have an immune system disorder? ..... YES NO
6. Have you receive blood transfusions or blood products, including immune globulin, in the past 5 months? ..... YES NO
7. Do you have close contact with newborns, pregnant women or immunocompromised persons? ..... YES NO
8. Have you been exposed to chickenpox? ..... YES NO
   When? _____

ZOSTAVAX (Shingles) **Suggested but patient refused** ☐

1. Have you ever had the chickenpox virus or been vaccinated against the chickenpox virus? ..... YES NO
2. Have you ever had a reaction to a chickenpox shot? ..... YES NO
3. Do you have ANY immune system problems? ..... YES NO
4. Have you ever had shingles in the past? ..... YES NO
5. Do you have any allergy to gelatin or neomycin? ..... YES NO
6. Have you ever been diagnosed with leukemia, lymphoma or other malignant neoplasms that affect the bone marrow or lymphatic system? ..... YES NO
7. Are you receiving daily topical, inhaled or low-dose oral corticosteroids? ..... YES NO
8. Is anyone in your household pregnant and has not had chickenpox? ..... YES NO
9. Does anyone in your household have problems with their immune system? ..... YES NO
10. Are you planning to become pregnant in the next 3 months? ..... YES NO

RAB-ID (Rabies Pre-exposure)

RAB-IM (Rabies Post-exposure) **Suggested but patient refused** ☐

1. Have you had a previous rabies vaccination? ..... YES NO
2. Have you had a reaction to a previous rabies vaccination? ..... YES NO
3. Are you taking antimalarial drugs? ..... YES NO

YF (Yellow Fever) **Suggested but patient refused** ☐

1. Have you had a YF vaccination within the last 10 years? ..... YES NO
2. Did you have a reaction to previous YF vaccination? ..... YES NO
3. Do you have an allergy to eggs or neomycin? ..... YES NO
4. Have you received blood transfusions or blood products, including immune globulin, within the last 8 weeks? ..... YES NO

I have been given a copy and have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I request that the vaccination(s) marked be given to me or to the person named for whom I am authorized to make this request.

I give my consent to have this information put into the Wyoming Immunization Central Registry.

Signature _____ Date _____

I have reviewed a copy of the Wyoming Department of Health NOTICE OF PRIVACY PRACTICES and have had a chance to ask questions about how information will be used. Please initial _____.

I have been informed that my insurance company will be billed per my request, but if charges are applied to my deductible or denied due to my policy not covering this/these service(s), I will be billed. Please Initial_____.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Date _____ Signature of Client _____ Signature of Clinic Nurse _____

DATE	VACCINE	DOSAGE	SITE/ ROUTE	MFG/LOT#	NURSE	VIS DATE	COMMENTS