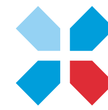
Screening Questionnaire for Adult Vaccination

DATE: ______________________



Patient Name: ______________________

Date of Birth: ______________________ Your age as of today: ______________________

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not get a vaccine. It just means that your health care provider may ask you additional questions. If a question is not clear, please ask your health care provider to explain it.

	YES	NO	UNSURE
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 heart disease, lung disease, asthma, kidney disease, metabolic disease (eg, diabetes), anemia or other blood disorder, no spleen, a cochlear implant, or spinal leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent or sibling with an immune system problem?	☐	☐	☐
7. In the past 6 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?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

This questionnaire is not intended to be a comprehensive list. If you have any other medical conditions, please discuss them with your health care provider.

Did you bring your immunization card with you? ☐ ☐

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

Form completed by: ______________________ Date: ______________________

Form reviewed by: ______________________ Date: ______________________

References: 1. Immunize.org. Screening checklist for contraindications to vaccines for adults. Published August 4, 2023. Accessed September 11, 2023. https://www.immunize.org/catg.d/p4065.pdf **2.** Miller E, Wodi P. General best practice guidance for immunization. In: Hall E, Wodi AP, Hamborsky J, Morelli V, Schillie S, eds. *Epidemiology and Prevention of Vaccine-Preventable Diseases* (Pink Book). 14th ed. Centers for Disease Control and Prevention; 2021:9-30. Updated August 18, 2021. Accessed June 13, 2023. https://www.cdc.gov/vaccines/pubs/pinkbook/genrec.html

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