PASSPORT HEALTH® Immunization Questionnaire

(Please print your answers)

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
(First) (Last) (MI) (Suffix)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ **Employer:** _____ **Occupation:** _____

Emergency Contact: _____
(Name) (Relationship) (Phone)

Sex*: Male ○ Female ○ Race*: _____ **Mother's Maiden Name*:** _____

***** *The answers to these questions are required in order to enter your immunization(s) into the state immunization registry.*

Insurance Information ***PLEASE ATTACH COPY OF INSURANCE CARD*** (Note: B12 is out-of-pocket only)*

Carrier Name: _____ **ID #:** _____ **Group #:** _____

1) Are you listed as the primary insured? Yes ○ No ○ If NO, please list Name and Date of Birth of primary:

Name: _____ **Date of Birth:** _____

2) Are you covered under any additional insurance plans? Yes ○ No ○ If YES, please list insurance information:
Carrier Name: _____ **ID #:** _____ **Group #:** _____

***ALL VACCINES**: Complete questions **1 through 5**, **THEN** complete the question(s) to right that correlate to your chosen vaccine

****FLU SHOT ONLY:** Complete **questions 1 through 5**

*****B12 INJECTION**: Please answer **question 17** ONLY

Shingles: Questions 6 – 11
FluMist: Questions 6 – 10
Pneumonia: Questions 12-14
Hep A/B: Question 15
Tdap: Question 16
MMR: Questions 6 - 10
B12: Question 17

Screening Questions

		Yes	No	Don't Know
1.	Are you sick today or have a high fever? **If YES, please explain:**	O	O	O
2.	Do you have an allergy to chicken, eggs, or any vaccine component? **If YES, please list or circle above:**	O	O	O
3.	Have you ever had a serious reaction after receiving a vaccination? **If YES, please explain:**	O	O	O
4.	Do you have paralysis, or a seizure or brain or other nervous system problem including Guillain- Barré Syndrome? **If YES, please explain or circle above:**	O	O	O
5.	**For women**: Are you pregnant or trying to become pregnant?	O	O	O
6.	Do you have cancer, leukemia, AIDS, or a history of autoimmune disease including MS, lupus, rheumatoid arthritis, Chron's, or IBD? **If YES, please list or circle above:**	O	O	O
7.	In the past 3 months, have you received chemotherapy or radiation treatments? **If YES, please explain:**	O	O	O
8.	In the past 4 weeks, have you received a cortisone, kenalog, or other steroid injection, or taken prednisone or any other steroid medication by mouth? **If YES, please list or circle above:**	O	O	O

DON'T FORGET TO SIGN AND DATE ON PAGE 2

PASSPORT HEALTH® Immunization Questionnaire

Shingles: Questions 6 – 11
FluMist: Questions 6 – 10
Pneumonia: Questions 12 -14
Hep A/B: Question 15
Tdap: Question 16
MMR: Questions 6 – 10
B12: Question 17

		Yes	No	Don't Know
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? **If YES, circle above:**	O	O	O
10.	Have you received any vaccinations in the past 4 weeks? **If YES, please list:**	O	O	O
11.	Have you received a shingles vaccine before? **If YES, please list mm/yr:**	O	O	O
12.	**(18 - 64 years)** Have you received a pneumonia vaccine before? **If YES, please list mm/yr:**	O	O	O
13.	**(18 – 64 years)** Do you smoke or do you have a long-term health problem such as heart disease, lung disease, asthma, COPD, kidney disease, or diabetes? **If YES, please circle above:**	O	O	O
14.	**(65 and older)** Have you received Pneumovax 23?	O	O	O
	Have you received Prevnar 13? **If YES, please list mm/yr:**	O	O	O
15.	Have you ever received the Hepatitis A or B series?	O	O	O
	Are you diabetic, are you a first responder, or do your job responsibilities require you to be exposed to bodily fluids, such as blood?	O	O	O
16.	Have you received a tetanus/diphtheria/pertussis(Tdap) vaccine in the last 7 -10 yrs?	O	O	O
17.	**(For B12 Only)** Do you have Leber's disease, an allergy to cobalamin, are you pregnant, breastfeeding, taking chloramphenicol medication, or have you had a serious reaction to a B-12 injection in the past?	O	O	O

Patient Signature:____________________________________Date:____________

Office Use Only

Vaccine:________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

Vaccine:________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

Vaccine:________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

Vaccine:________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

Vaccine:________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

B12:___________________________**Site:**_______________**Lot #:** ______________**Exp:** ____________________

Nurse provided immunizations to patient without difficulty and patient was observed showing no adverse reaction. **Nurse initials:_____ Immunizations were given on: Date:____________**

1 – RIGHT Upper Delt (IM) **2** – LEFT Upper Delt (IM) **3** – RIGHT Mid Delt (IM) **4** – LEFT Mid Delt (IM) **5** – RIGHT Mid Lat (SQ) **6** – LEFT Mid Lat (SQ)

Nurse Notes: