Screening Questionnaire for Vaccination

HPV 1 _____(now) Tetanus Flu
2 _____(2 months after 1st; not < 28 days)
3 _____(6 months after 1st; 6-12 months)

Patient Name: _____DOB:_____Date:_____

S:

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask your healthcare provider to explain it.			
	Yes	**No**	**Don't Know**
1. Have you ever had a reaction to yeast?			
2. Do you have a sensitivity to eggs or egg products or other severe food allergies?			
3. Do you have a history of Gillian-Barre Syndrome?			
4. Are you sick today?			
5. Do you have a known sensitivity to Thimersol (a preservative in vaccines)?			
6. Have you ever had a serious reaction after receiving a vaccine?			
7. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
8. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had any radiation (x-ray) treatments?			
9. During the past year, have you received a transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?			
10. ** Are you pregnant or is there a chance you could become pregnant during the next 3 months?			
11. ** Have you received any vaccinations in the past 4 weeks?			
12. ** Are you currently breastfeeding?			

O: BP _____ WT _____

A: Eligible for HPV vaccine today ? Y_____ N_____

P: Administer vaccine.

Gardasil_____ Other_____	Lot #: Expiration Date: _____	Site:_____

I understand that if I am over the age of 26 that the HPV vaccine is not currently recommended by the FDA, because it has not been studied in this age group, and may not be covered by my insurance.

I also understand that it is my responsibility to ascertain if my insurance will cover the vaccine that I have requested. I am responsible for partial or full payment if not covered.

Patient Signature _____ Date _____

Reviewed by _____ Date _____