MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHLTHCLINICPAXRIVINST 6230.3N CH-1	28 MAY 2013

LOCAL FORM TITLE *(Optional)*

VACCINE QUESTIONNAIRE

Patients/ Parents/ Guardians: Please answer the following questions. Your responses will help us identify the vaccines that can be safely given today. If you have any questions regarding this questionnaire, please have the nurse or doctor clarify.

	Yes	No	N/A
1. Are you/patient/child ill today?	☐	☐	☐
2. Is there any possibility that you/patient/child are (is) pregnant or could become pregnant within the next month?	☐	☐	☐
3. Do you or does patient/child have allergies to any of the following?			
A. Eggs (Influenza, Yellow Fever).....	☐	☐	☐
B. Thimerosal (Pneumovax, JEV, Meningococcal).....	☐	☐	☐
C. Gelatin (MMR, Varivax, Zostavax).....	☐	☐	☐
D. Formalin (Typhus, Plague).....	☐	☐	☐
E. Phenol (Cholera, Pneumovax, Plague)	☐	☐	☐
F. Beef Protein, Soy, or Casein (Plague).....	☐	☐	☐
G. Neomycin/Streptomycin (IPV, MMR, Varivax, Zostavax).....	☐	☐	☐
H. Baker's Yeast (Hepatitis B, HPV).....	☐	☐	☐
I. Rubber/Latex.....	☐	☐	☐
J. Medication_____.....	☐	☐	☐
4. Do you or does patient/child have a history of any adverse reactions to any vaccines in the past?	☐	☐	☐
5. Do you or does patient/child take any blood thinner like Coumadin and /or you or does patient/child have any bleeding problems?	☐	☐	☐
6. Do you or does patient/child or anyone that lives with you or acts as caregiver have cancer, leukemia, AIDS transplantation, or any other immune system problem?	☐	☐	☐
7. Have you or has patient/child received a transfusion of blood, plasma or immune (gamma) globulin in the past 6 months?	☐	☐	☐
8. Have you or has patient/child or anyone who lives with or takes care of the patient taken cortisone, prednisone, or other steroids, anti -cancer drugs or X-Ray irradiation treatment in the past 3 months?	☐	☐	☐
9. Have you or has the patient/child ever been diagnosed with Guillain Barre Syndrome?	☐	☐	☐

PATIENT'S NAME	PATIENT'S SIGNATURE	DATE

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

HOSPITAL OR MEDICAL FACILITY	STATUS

DEPARTMENT / SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN

RELATIONSHIP TO SPONSOR