FALL CREEK INTERNAL MEDICINE, LLP
SCREENING QUESTIONNAIRE FOR VACCINES

Patient Name: _____ DOB: _____

Please answer these questions by checking the boxes. If unclear, please ask your healthcare provider for clarification.

1. Are you sick today?
   Yes_____ No_____ Unsure_____

2. Do you have allergies to medications, food (eggs), a vaccine component (such as Thiomersal, used as a preservative), or latex?
   Yes_____ No_____ Unsure_____

3. Have you had a serious reaction after receiving a vaccination?
   Yes_____ No_____ Unsure_____

4. Do you have a long-term health problem with heart, lung, kidney or metabolic (diabetes) disease, asthma or blood disorders?
   Yes_____ No_____ Unsure_____

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune symptom problems?
   Yes_____ No_____ Unsure_____

6. In the past three months have you taken Cortisone, Prednisone, other steroids or anticancer drugs? Cellcept, Humira, Remicade, Enbral? Have you had radiation treatment?
   Yes_____ No_____ Unsure_____

7. Have you had a seizure or brain or other nervous system problem?
   Yes_____ No_____ Unsure_____

8. During the last year have you received a blood transfusion?
   Yes_____ No_____ Unsure_____

9. For women: Are you pregnant or is there a chance you may become pregnant in the next 3 months?
   Yes_____ No_____ Unsure_____

10. Have you received any vaccines in the last four weeks? (Notes: Zostovax and Pneumococcal should be given 30 days apart. Verify vaccine schedule for Pneumovax or Prevnar.)
    Yes_____ No_____ Unsure_____

I understand the benefits and risks of vaccination as described in the vaccine information sheet. I request that the vaccination be given to me or the person named above for whom I am authorized to sign.

Signature: _____ Date: _____

Vaccine #1_____ Lot#_____ R / L Vaccine(s) given by: _____

Vaccine #2_____ Lot#_____ R / L Billing complete: _____

Vaccine #3_____ Lot#_____ R / L

If patient has Medicare please, use Pneumovax (G0009) and Influenza (G0008) for billing.