Comprehensive Internal Medicine

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Immunization Administration

Patient Name: _____ D.O.B:_____/_____/_____

_____ *Gardasil*	_____ *Meningococcal*	_____ *Pnemovax*	_____ *Tdap Booster*	***Influenza:***
_____ *Hepatitis A*	_____ *Meningococcal Serogroup B*	_____ *Prevnar*		_____*Quadravalent*
_____ *Hepatitis B*	_____ *MMR*	_____ *Shingrix*		_____ *Flublok*
				_____ *High Dose*

Screening Questions: please circle

1. Are you sick today? **No Yes** If yes, explain: _____
2. Do you have an allergies? **No Yes** If yes, list: _____
3. Have you ever had a serious reaction after receiving a vaccination? **No Yes**
   If yes,explain:_____
4. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e. diabetes), anemia, or other blood disorders? **No Yes**
5. Do you have cancer, leukemia, AIDS or any other immune system disorder? **No Yes**
   If yes, list: _____
6. Do you take cortisone, prednisone, other steroids, anti-cancer drugs, or have you had x-ray treatments? **No Yes** If yes, list: _____
7. During the past year, have you received a blood transfusion or transfusion of blood products, or been given injections of immune (gamma) globulin? **No Yes** If yes, list: _____
8. For women: Are you pregnant or is there a chance that you could become pregnant during the next month? **No Yes**
9. Have you received any vaccinations in the past four (4) weeks? **No Yes** If yes, list: _____
10. Do you have a hypersensitivity to any component of the vaccine, including thimerosal? **No Yes**
11. Do you have a hypersensitivity to chicken eggs or egg protein? **No Yes**

A copy of your immunization record will be kept on file. As a courtesy to our patients, we are pleased to file an insurance claim on your behalf for the immunizations you receive today. While not all insurance companies cover the cost of vaccines; we will do our best to gain reimbursement for your visit today. Please know that any remaining balance on your account will become your responsibility. MEDICARE PATIENTS-Medicare Part B may not cover some vaccinations. Please speak with a billing representative to discuss your payment options.

Patient Signature : _____ **Date:** _____/_____/_____ **MA Initials:** _____

Vaccine Sticker:

Site Location:

_____

Vaccine Sticker:

Site Location:

_____