Patient History

Patient Name: _____ Date: _____

Address: _____

_____ DOB: _____

Phone #:(___)____-_____

Please read the questions below. Indicate YES or NO of the person receiving a vaccine today.

	YES	NO
1. Has this person ever had severe reaction to any vaccine, which required medical care?	_____	_____
2. Is this person allergic to eggs, baker's yeast, streptomycin or neomycin?	_____	_____
3. Does this person have fever, diarrhea or vomiting today?	_____	_____
4. Is this person or anyone in the home being treated With chemotherapy, radiation for cancer; have HIV/ AIDS, or any immune deficiency disease?	_____	_____
5. Does this person smoke?	_____	_____
6. Is his person receiving treatments for any Disease or illness?	_____	_____
7. Has this person been under a doctor's care in the Past year?	_____	_____
8. Has this person had immune globulin or a blood Transfusion in the past year?	_____	_____
9. Has this person had Gullian-Barre syndrome (a Condition which causes paralysis)	_____	_____
10. Is this person pregnant, or planning pregnancy in The next three months.	_____	_____
11. List all prescriptions or over the counter medications That this person is taking.		

Consent for Administration of Vaccine

I have read, or have had read to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below to:

_____

Name(print)

_____

Signature

Vaccine Name	Date	Site	Manufacturer	Lot #	Exp	Admin Sig
		L R				