



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## CLINIC SCREENING FORM FOR ADULTS

Answering the following questions will help us provide better care for you. If a question is not clear, please ask the nurse or doctor to explain it.

|   | Yes                      | No                       | Don't Know               |
|---|--------------------------|--------------------------|--------------------------|
| 1. Are you sick today?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, or any vaccine?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction to a vaccine in the past?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, Asthma, kidney disease, metabolic disease (ie; diabetes), anemia or other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS or any other immune system disorder?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you take cortisone, prednisone, other steroids, or anticancer drugs or have you had x-ray treatments?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure, brain, or other nervous system problem?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you received a transfusion of blood products, or been given a Medicine called immune (gamma) globulin in the past year?                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. For Women: Are you pregnant or is there a chance you could become pregnant during the next month?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you receiving vaccinations today as a college/school requirement?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your immunization record with you?**                      **Yes**                      **No**