

## Immunization Screening Questionnaire

Name of person getting immunized \_\_\_\_\_ Date of Birth \_\_\_\_\_

Are you here for: **(please check all that apply)**

- Routine immunizations (child, adult or school required)? *If yes, please fill out Sections I & II below.*
- Immigration? *If yes, please fill out Sections I & II below.*
- An injury? *If yes, please fill out Section I below.*
- An animal bite? *If yes, please fill out Section I below.*
- A human bite, a needle stick, or blood/body fluid exposure? *If yes, please fill out Sections I, II & III below.*
- Being around someone with hepatitis? *If yes, please fill out Sections I & III below.*

**Please circle answers to these questions about the PERSON receiving the immunizations:**

<b>I – General questions:</b>		
1. Are you sick today? .....	NO	YES
2. Do you have cancer, AIDS, or other immune system problems, or have you taken any steroids, anti-cancer drugs, or radiation in the last 3 months? .....	YES	NO
3. Have you received any other immunizations in the last 28 days? .....	YES	NO
4. Have you ever had a problem with any previous immunization? .....	YES	NO
5. Have you ever fainted while getting an immunization? .....	YES	NO
6. Have you ever had a blood clotting disorder? .....	YES	NO
7. Have you been told you have an allergy to the antibiotics streptomycin or neomycin? .....	YES	NO
8. Do you have any brain problems? .....	YES	NO
9. Are you pregnant? .....	YES	NO
10. Do you plan to become pregnant in the next 28 days? .....	YES	NO
Last menstrual period if applicable: Date _____ Signature _____		

<b>II – Vaccine Specific Questions</b>		
<b>Polio</b>		
1. Are you allergic to streptomycin, neomycin, or polymyxin B? .....	YES	NO
<b>Measles/Mumps/Rubella &amp; Varicella</b>		
1. Have you received immune globulin or a blood transfusion in the last 11 months? .....	YES	NO
2. Are you allergic to gelatin or neomycin? .....	YES	NO
<b>Hepatitis B</b>		
1. Are you allergic to any kind of yeast? .....	NO	YES
2. Did your baby get a hepatitis B immunization in the hospital? .....	NO	YES
3. Were you born outside of the U.S.? If yes, where? .....	YES	NO
<b>Hepatitis A</b>		
1. Are you allergic to alum or phenol? .....	YES	NO

<b>III- Hepatitis</b>				
1. Did this person have hepatitis:	A?	B?	C?	Don't know?
2. Did someone at the Health Department ask you to come in? If yes, who? .....	YES	NO		
3. Were you told to come in for immune globulin? .....	YES	NO		
4. Have you ever been told you have hepatitis B? .....	YES	NO		
5. Are you here for a Havrix (hepatitis A) immunization today? .....	YES	NO		
If yes, why? _____				

**Client/Parent Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent signature required if under 18 years old

Office use only:		
<input type="checkbox"/> Tetanus/wound care – handout and discussion	<input type="checkbox"/> Blood/Body fluid exposure - handout and discussion	<input type="checkbox"/> Referred for travel consult
<input type="checkbox"/> Bite wound management - handout and discussion	<input type="checkbox"/> Foreign Born - handout and discussion	
Client signature _____		
Comments _____		

**MEDICAID clients please present eligibility card**

WASHOE COUNTY DOES NOT DISCRIMINATE ON THE BASIS OF SEX, RACE, COLOR, AGE, RELIGION, DISABILITY OR NATIONAL ORIGIN IN THE ACTIVITIES AND/OR SERVICES WHICH IT PROVIDES.  
IF YOU HAVE ANY QUESTIONS PLEASE CALL WASHOE COUNTY PERSONNEL DIVISION AT 328-2080. TDD NUMBER 328-3685.

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