

DATE: 2/11/11 TIME: 1055 PT. HISTORY REVIEWED / UPDATED _____ / _____

PRESENT COMPLAINT: Pt in for travel vaccine (polio) to India. Pt to receive malaria Rx from family physician. ^{Wm}

Temp	Pulse	Resp	B/P	HT	WT	ALLERGIES
						Sulfa, zithromax
INITIAL VISIT						

DIAGNOSIS:	<u>TESTS</u>	<u>RESULTS</u>

CALL BACK:

STAFF
SIGNATURE: [Signature]

COMMENTS.

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

AUBURN UNIVERSITY MONTGOMERY
NURSING CARE CENTER

Name: Jaime Address

IRMA B. MOORE HALL RM. 102

Date of birth: 5/28/82 Record #

P.O. BOX 244023

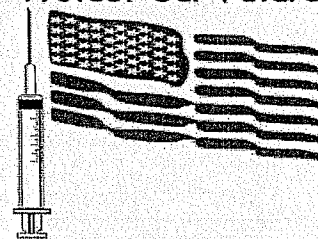
Allergies: sulfa, Azithromycin

MONTGOMERY, AL 36124-4023

Reactions:

History of Chickenpox? YES or NO If yes, date if known:

Protect Our Future!



Immunize!

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV	2	11	28		Polio	1	00	SP	D0480-1	0.5cc	LD	RT	lgow
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M = Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

**Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

***VIS Language given, if not English:

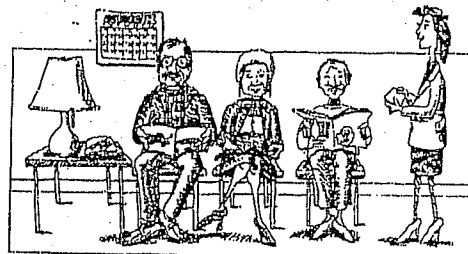
Patient name:

Jim Andress

Date of birth:

5 / 18 / 02
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, or any vaccine?	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☒	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☒	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

Form completed by:

Jim Andress

Date:

3/9/11

Form reviewed by:

Date:

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

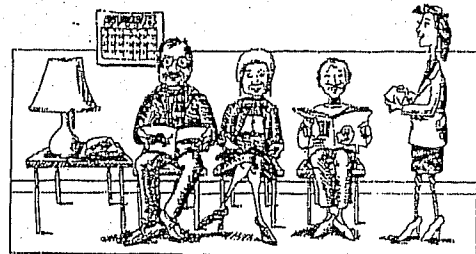
Technical content reviewed by the Centers for Disease Control and Prevention, April 2009.

www.immunize.org/catg.d/p4065.pdf • Item # E4065 (4/09)

Patient name:

Jaime AndressDate of birth: 5/18/82
(mo.) (day) (yr.)

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Form completed by:

Jaime Andress

Date:

2/14/2011

Form reviewed by:

[Signature]

Date:

2/11/2011**Did you bring your immunization record card with you?**yes ☒ no ☐

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