

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Wanshan Dai
DATE OF BIRTH 3/21/1998
month day year

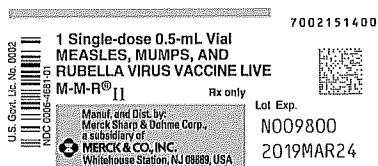
For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare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

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
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, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a 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 Wanshan Dai DATE 8/18/2007
FORM REVIEWED BY [Signature] DATE 8/18/17

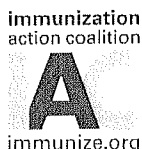
Did you bring your immunization record card with you? yes ☐ no ☐

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.



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Technical content reviewed by the Centers for Disease Control and Prevention
www.immunize.org/catg.d/p4065.pdf • Item #P4065 (10/16)

Immunization Record

Name: _____

D.O.B: _____

Sex: M ☐ F ☐

Vaccine and Dose Number	Vaccine Manufacturer	Date Vaccine Given			Provider Signature Clinic Stamp	Date Next Due
		Month	Day	Year		
Hepatitis B 1						
Hepatitis B 2						
Hepatitis B 3						
Circle Type						
DTaP/DTP/DT 1						
DTaP/DTP/DT 2						
DTaP/DTP/DT 3						
DTaP/DTP/DT 4						
DTaP/DTP/DT 5		expired 8	30	03	CMHC - Good Hope Rd	
Circle Type						
DTP-Hib 1						
DTP-Hib 2						
DTP-Hib 3						
DTP-Hib/DTaP-Hib 4						
Hib 1						
Hib 2						
Hib 3						
Hib 4						
Hib-Hep B 1						
Hib-Hep B 2						
Hib-Hep B 3						
Td 1						
Td 2						
Td 3						
Td 4						
Circle Type						
OPV/IPV 1						
OPV/IPV 2						
OPV/IPV 3						
OPV/IPV 4						
Pneu Con (PCV7) 1						
Pneu Con (PCV7) 2						
Pneu Con (PCV7) 3						
Pneu Con (PCV7) 4						
MMR 1						
MMR 2		8	30	03	CMHC - Good Hope Rd	
Varicella 1						
Varicella 2						
Chickenpox (varicella) Yes ☐ No ☐						
Disease History						
When: Month _____ Year _____						

Immunization Record

Name:

D.O.B:

Sex: M ☐ F ☐

Vaccine and Dose Number	Vaccine Manufacturer	Date Vaccine Given			Provider Signature Clinic Stamp	Date Next Due
		Month	Day	Year		
Hepatitis B 1						
Hepatitis B 2						
Hepatitis B 3						
Circle Type						
DTaP/DTP/DT 1						
DTaP/DTP/DT 2						
DTaP/DTP/DT 3						
DTaP/DTP/DT 4						
DTaP/DTP/DT 5		8	30	03	CNIC - Good Hope Rd	
Circle Type						
DTP-Hib 1						
DTP-Hib 2						
DTP-Hib 3						
DTP-Hib/DTaP-Hib 4						
Hib 1						
Hib 2						
Hib 3						
Hib 4						
Hib-Hep B 1						
Hib-Hep B 2						
Hib-Hep B 3						
Td 1						
Td 2						
Td 3						
Td 4						
Circle Type						
OPV/IPV 1						
OPV/IPV 2						
OPV/IPV 3						
OPV/IPV 4						
Pneu Con (PCV7) 1						
Pneu Con (PCV7) 2						
Pneu Con (PCV7) 3						
Pneu Con (PCV7) 4						
MMR 1						
MMR 2		8	30	03	CNIC - Good Hope Rd	
Varicella 1						
Varicella 2						
Chickenpox (varicella) Yes ☐ No ☐ When: Month _____ Year _____						