UCSB SHS IMMUNIZATION CLINIC QUESTIONNAIRE

Patient name: ______________________ **Perm#**: ___________ **Age:** _____

I would like the following immunizations today:

Varivax (Chickenpox) Hepatitis A Hepatitis B Twinrix (Hepatitis A&B) Gardasil (HPV) Influenza Influenza-Nasal Meningococcal MMR (Measles/Mumps/Rubella) Polio Pneumovax (Pneumococcal)	Td (Tetanus/Diphtheria) Tdap (Tetanus/Diphtheria/Pertussis) Vaccines for Travel* Japanese encephalitis* Rabies* Typhoid * Yellow Fever* ***Travel visit required for these vaccinations**

Yes No

1. Are you feeling ill today?

2. Do you have allergies to medications, food, latex or any vaccine?

3. Have you ever had a serious reaction after receiving a vaccination?

4. Do you have any current or ongoing health problems such as heart, lung thymus, kidney disease, metabolic disease (i.e. diabetes), or blood disorder?

5. Do you have cancer, leukemia, AIDS, or any other immune system problem?

6. In the past 3 months, have you taken cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments?

7. Have you ever 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. Women: Are you pregnant, trying to become pregnant during the next month, or breastfeeding?

10. Have you received any other vaccinations in the past 4 weeks?

11. Do you currently reside with anyone who is immunocompromised?

I have been advised for my safety to remain in the lobby for 15 minutes following my immunization.

Patient Signature_________________________ **Date**____________

Clinician Signature________________________ **Date**____________

in approval