



FELLOWS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS DIPLOMATES, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

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Screening Questionnaire for Adult Immunization

Patient name: _____ **D.O.B** __/__/__

For patient: 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, or vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?	<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 (e.g., diabetes), anemia, or another blood disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<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 treatment?	<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. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<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"/>
Did you bring your immunization card with you? It is important for you to have a personal record of your vaccines. If you don't have a personal record, ask your healthcare provider to give you one. Bring it with you every time you seek medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form Received by: _____ Date: _____