PASSPORT HEALTH® Immunization Questionnaire

(Please print your answers)

Patient Name: _____ **Date of Birth:** _____ **Age:** ____
(Last) (First) (M I) (Suffix)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ **Employer:** _____ **Occupation:** _____

Emergency Contact: _____
(Name) (Relationship) (Phone)

Sex*: Male ○ Female ○ Race*: _____ **Mother's Maiden Name*:** _____

** The answers to these questions are required in order to enter your immunization(s) into the state immunization registry.*

Insurance Information ******PLEASE ATTACH COPY OF INSURANCE CARD*** (Note: B12 is out-of-pocket only)***

Carrier Name: _____ **ID #:** _____ **Group #:** _____
(HealthChoice members do not have a Group #)

Are you listed as the primary insured? Yes ○ No ○ If no, please list Name and Date of Birth of primary:

Name: _____ **Date of Birth:** _____

*B12 INJECTION: Please answer **question 17** ONLY.
FLU SHOT: Complete **questions 1 through 5 ONLY.
***ALL OTHER VACCINE: Complete questions **1 through 5, THEN** complete the question(s) to the right that correlate to your chosen vaccine.

Shingles: Questions 6 – 11
FluMist: Questions 6 – 11
Pneumonia: Questions 12-14
Hep A/B: Question 15
Tdap: Question 16
B12: Question 17

Screening Questions

		Yes	No	Don't Know
1.	Are you sick today or have a high fever? **If YES, please explain:**	O	O	O
2.	Do you have an allergy to chicken, eggs, or any vaccine component? **If YES, please list:**	O	O	O
3.	Have you ever had a serious reaction after receiving a vaccination? **If YES, please explain:**	O	O	O
4.	Do you have paralysis, or a seizure or brain or other nervous system problem including Guillain- Barré Syndrome? **If YES, please explain:**	O	O	O
5.	**For women**: Are you pregnant or is there a chance you may become pregnant during the next month?	O	O	O
6.	Do you have cancer, leukemia, AIDS, or a history of autoimmune disease including MS, lupus, rheumatoid arthritis, Chron's, or IBD? **If YES, please list:**	O	O	O
7.	In the past 3 months, have you received chemotherapy or radiation treatments? **If YES, please list:**	O	O	O
8.	In the past 4 weeks, have you received a cortisone, kenalog, or other steroid injection, or taken prednisone or any other steroid medication by mouth? **If YES, please list:**	O	O	O

DON'T FORGET TO SIGN AND DATE ON PAGE 2

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		Yes	No	Don't Know
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? **If YES, please list:**	O	O	O
10.	Have you received any vaccinations in the past 4 weeks? **If YES, please list:**	O	O	O
11.	Have you received a shingles vaccine before? **If YES, please list mm/yr:**	O	O	O
12.	**(64 and younger)** Have you received a pneumonia vaccine before? **If YES, please list mm/yr:**	O	O	O
13.	**(64 and younger)** Do you currently smoke or do you have a long-term health problem with heart disease, lung disease, asthma, COPD, kidney disease, or diabetes? **If YES, please list:**	O	O	O
14.	**(65 and older)** Have you received Pneumovax 23?	O	O	O
	Have you received Prevnar 13? **If YES, please list mm/yr:**	O	O	O
15.	Have you ever received the Hepatitis A or B series?	O	O	O
	Are you diabetic, are you a first responder, or do your job responsibilities require you to be exposed to bodily fluids, such as blood?	O	O	O
16.	Have you received a tetanus/diphtheria/pertussis (Tdap) vaccine in the last 7 to 10 years?	O	O	O
17.	**(For B12 Only)** Do you have Leber's disease, an allergy to cobalamin, are you pregnant, breastfeeding, taking chloramphenicol medication, or have you had a serious reaction to a B-12 injection in the past?	O	O	O

Patient Signature:_______________________________ **Date:**__________

Office Use Only

Vaccine:____________________ **Site:**____________ **Lot #:** ____________ **Exp:** ________________

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Vaccine:____________________ **Site:**____________ **Lot #:** ____________ **Exp:** ________________

B12:______________________ **Site:**____________ **Lot #:** ____________ **Exp:** ________________

Nurse provided immunizations to patient without difficulty and patient was observed showing no adverse reaction. Nurse initials:_____ Immunizations were given on: Date:__________