Revised 1/24/2023

Immunization Screening Questionnaire

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.

Patient Name: _____ Date of birth:_____

Please answer for the person getting vaccines:	Yes	No	Don't Know
1. Sick today?	☐	☐	☐
2. Allergies to medications, food, latex or any vaccines?	☐	☐	☐
3. Serious reaction to a vaccine in the past?	☐	☐	☐
4. Have/had asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), liver disease, a blood disorder, no spleen, complement component deficiency, a cochlear implant, a spinal fluid leak, or been on long term aspirin therapy? If yes, circle all that apply.	☐	☐	☐
5. Self, sibling, or parent ever had a seizure, paralysis, or a problem with the brain or nervous system? If yes, circle all that apply.	☐	☐	☐
6. Self, sibling, or parent ever had cancer, leukemia, AIDS, or any other immune system problem? If yes, circle all that apply.	☐	☐	☐
7. In the past 3 months, taken cortisone, prednisone, other steroids, anticancer drugs; drugs for rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
8. In the past year received a blood transfusion, blood product, been given a medicine called immune (gamma) globulin or an antiviral drug? If yes, circle all that apply.	☐	☐	☐
9. If applicable: Pregnant or planning on becoming pregnant in the next month?	☐	☐	☐
10. Received any vaccinations in the past 4 weeks?	☐	☐	☐
11. Had Chickenpox disease?	☐	☐	☐
12. Needs a TB (tuberculosis) test in the next 4 weeks?	☐	☐	☐
13. For child is between 2 and 4 years old: In the past year, has a health care provider told you that the child had wheezing or asthma?	☐	☐	☐
14. If your child is a baby, have you ever been told he or she has had intussusceptions?	☐	☐	☐
15. Currently taking influenza antiviral medication, or have taken within past 3 weeks?	☐	☐	☐

Signature of person completing the form:_____ Date: _____

Nurse's signature:_____ Date: _____

Interpreter Use

Pacific Interpreters: Yes ☐ No ☐

In-person Interpreter: Yes ☐ No ☐ Name:_____

Declined: Yes ☐ No ☐

Public Health
MADISON & DANE COUNTY
Healthy people. Healthy places.