Redpoint MEDICAL PSC
128 Southland Dr, Suite 110
Lexington, KY 40503

Screening Questionnaire for Injectable Vaccines

Patient Name: _____ Today's Date: _____

Date of Birth (month/day/year): _____ Temperature: _____

HEALTH STATUS

Please list all prescription medications the patient is currently taking:

_____

Has the patient taken any antibiotics in the last 3 days? ( ) No ( ) Yes. If yes, please list: _____

Date of patient's last physical exam?_____

Does the patient have a family history of any significant medical problems/diseases? ( ) No ( ) Yes

Please describe: _____

Does the patient currently have any health issues related to the following:

( ) Heart	( ) Stomach/Bowel	( ) Eyes	( ) Fatigue
( ) Lungs	( ) Diabetes	( ) Ears	( ) High Blood Pressure
( ) Liver	( ) Skin	( ) Spinal/Brain	( ) Mental Illness
( ) Kidney	( ) Seizure	( ) Bladder/Urinary	( ) None/ Systems Negative

( ) Other; please describe: _____

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

The following questions help us to determine which vaccines you are eligible to receive today. Answering "yes" to any of these questions does not necessarily mean that you cannot be vaccinated. We may just need additional information to make appropriate determinations.

1. Is the patient feeling sick today? ( )No ( )Yes

2. Does the patient have any allergies to medications, foods (including eggs), or a vaccine component (including Thimerosol, hydrocortisone, and gentamicin sulfate)? ( )No ( )Yes
   If yes, please specify:_____

3. Has the patient ever had a serious reaction after receiving a vaccination? ( )No ( )Yes

4. Has the patient ever been diagnosed with Guillain-Barre syndrome? ( )No ( )Yes

(please complete the form on back)

5. Is the patient currently undergoing anticoagulant therapy or been diagnosed with a bleeding disorder? ( )No ( )Yes

6. Does the patient have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? ( )No ( )Yes

7. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? ( )No ( )Yes

8. Does the patient have a parent, brother, or sister with an immune system problem? ( )No ( )Yes

9. In the past three months, has the patient taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or has the patient had radiation treatments? ( )No ( )Yes

10. Has the patient or an immediate family member had a seizure or other brain or nervous system problem? ( )No ( )Yes

11. During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ( )No ( )Yes

12. Has the patient received any vaccinations in the last 28 days? ( )No ( )Yes

13. Female Patients Only: Date of last menstrual period?_____

    Are you currently pregnant? ( ) No ( ) Yes

    Are you breast feeding? ( ) No ( ) Yes

    Are you planning to become pregnant in the next 30 days? ( ) No ( ) Yes

14. For Parents of Children Under the Age of Four Only:

    If the patient is between two and four years of age, has his/her healthcare provider told you that the child had wheezing or asthma in the past 12 months? ( )No ( )Yes

    If the patient is a baby, have you ever been told that he or she has had intussusception? ( )No ( )Yes

15. Do you have any questions or concerns about vaccines that you would like to discuss? ( )No ( )Yes

The information provided in This Screening Questionnaire for Injectable Vaccines is correct to the best of my knowledge. I will not hold Redpoint Medical nor its medical provider(s) or employee(s) responsible for any errors or omissions that I may have made in completing this form.

Patient Signature:_____ **Date:**_____

Reviewed By:_____ **Date:**_____