## Immunization Questionnaire

- **Are you sick today?**

- **Do you have allergies to medications, food, latex, thimerosal, or any vaccine?**

- **Have you ever had a serious reaction after receiving a vaccination?**

- **Have you taken cortisone, prednisone, other steroids, anticancer drugs, or have had radiation treatments in the past 3 months?**

- **Have you had a seizure, brain, or other nervous system problem?**

- **During the past year, have you received a transfusion of blood or blood products, or been given Immune (gamma) globulin or an antiviral drug?**

- **Have you received any vaccinations in the past 4 weeks?**

- **Women Only: Are you pregnant or is there a chance you could become pregnant during the next month?**

**Vaccines given: (check all that apply)**

TdaP (90715) Td (90714)PPV 13 (90670) PPV23 (90732) Varicella (90716)
Zostavax (90736) Shingrix (90750) COVID-19

**Patient Name:** **Date of Birth:**

**Patient Signature:** **Today's Date:**



Last modified: 03/13/2021