JENSEN'S COMMUNITY PHARMACY
IMMUNIZATION QUESTIONNAIRE

Patient Name:_________________________________
Address:____
Date of Birth:_______________
Phone: ____________________

Type of Vaccination today:_________________

Questionnaire *(Please circle one):*

1. Are you sick today? *Yes No Don't Know*

2. Do you have allergies to medications, food, or any vaccine? *Yes No Don't Know*
*If yes please list:*_____________________________________

3. Have you ever had a serious reaction after receiving a vaccination?
Yes No Don't Know

4. Do you have cancer, leukemia, AIDS, or any other immune system problem?
Yes No Don't Know

5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *Yes No Don't Know*

6. During the last year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?
Yes No Don't Know

7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *Yes No Don't Know*

8. Have you received any vaccinations in the past 4 weeks? *Yes No Don't Know*
If yes which vaccination?______________________

Form completed by:________________________________ Date:___________

I Authorize the billing of third party insurance including Medicare Part B
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