Screening Checklist
for Contraindications
to Vaccines for Adults

YOUR NAME: _____

DATE OF BIRTH: ____/____/____

PHONE # _____

For patients: 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 we need to ask you more questions. If a question is not clear, please ask your health care provider to explain it.

1. Are you sick today? **Y OR N**

2. Do you have **allergies** to medications, food, a vaccine component, or latex? **Y OR N**

3. Have you ever had a serious reaction after receiving a vaccine? **Y OR N**

4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? **Y OR N**

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? **Y OR N**

6. Do you have a parent, brother, or sister with an immune system problem? **Y OR N**

7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? **Y OR N**

8. Have you had a seizure or a brain or other nervous system problem? **Y OR N**

9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? **Y OR N**

10. Are you pregnant? **Y OR N**

11. Have you received any vaccinations in the past 4 weeks? **Y OR N**

12. Have you ever felt dizzy or faint before, during, or after a shot? **Y OR N**

PATIENT SIGNATURE: _____ DATE: _____

FORM REVIEWED BY: _____ DATE: _____