Patient ID_____ Temp_____C

PRIMARY CARE TOKYO

Pre-vaccination Screening Questionnaire

The following questions will help us determine if we can safely vaccinate you today.

Please ask the doctor to explain anything that is not clear to you prior to the vaccination.

Patient Name		Date of Birth	/ / (Mo. / Day / Yr)

	Yes	No	Don't know
1. Are you sick today?			
2. Do you have any allergies to medications, food or vaccines?			
3. Have you ever had a severe reaction to any vaccine in the past?			
4. Have you ever had any diseases of the nervous system?			
5. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problems?			
6. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, or any other steroid medications?			
7. Do you, any person who lives with you, or any person you take care of receive chemotherapy or radiation therapy?			
8. Have you received blood transfusions or other blood products or immunoglobulin in the past year?			
9. Have you received any other vaccinations in the past 4 weeks?			
10. For women: Are you pregnant or is there a chance you could become pregnant in the next three months?			

I have read the information provided regarding the vaccine(s) and understand the risks and benefits of the vaccinations planned for administration. My questions have been answered and I agree to the administration of the vaccine(s).

_____ _____

Signature Date