

Albers Medical Pharmacy Vaccine Questionnaire Form

Name: _____ Today's Date ___/___/___

Address: _____ City/St: _____ Zip: _____

Phone #: () _____ - _____ Email Address: _____

SSN: ___ - ___ - _____ Date of Birth: ___/___/___ Sex: M/F

***** please make sure the following information *****
***** is complete and accurate *****

Departure Date: ___/___/___ Return Date: ___/___/___

Countries you plan to visit (in sequence):

Country	urban	rural	duration?	Purpose of visit(activities)
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Prior Immunizations:

	<u>received vaccine before?</u>				<u>last booster?</u>
	Yes	Probably	No	Not sure	Approx. Date
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inj. Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Measles/MMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inj. Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Tetanus-Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Japanese Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumococcal Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rabies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*****

Have you ever had measles or hepatitis A? Y/N if yes which one? _____

Have you received immune globulin, a blood transfusion, or other blood products in the last 3 months? Y/N

Please provide us with your primary Physician's name: _____ Phone # _____

**Please check the appropriate box if any of these situations apply to you:**

- Born after 1956 and have had fewer than two doses of **Measles** or **MMR** vaccine
- Expect prolonged or close contact with large masses of underprivileged populace in a developing nation (**Measles, Diphtheria, Meningococcal, TB, Hepatitis B, Polio**)
- Will be providing medical care to disadvantaged people (**Measles, Diphtheria, Meningococcal, TB, Hepatitis B, Polio**)
- Will be traveling to an area with active **Polio** and have not had at least 3 **Polio** vaccine doses and a booster as an adult
- Expect poor food and water sanitation in Central or South America, southern or eastern Europe, Asia or Africa (**Typhoid, Hepatitis A**)
- Anticipate heavy mosquito bite exposure in a region with **Malaria**
- May become pregnant at some future time and have not had a **Rubella** vaccine
- Never had chickenpox

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**Medical History** (check all if true):

- I was raised outside of the U.S.A
- I am not sure I received all of my childhood vaccines
- I have had an allergic reaction to eggs
- I am allergic to thimerosal (mercury derivative)
- I have fainted after shots or drawing blood
- I have had an allergic reaction to any vaccine
- Surgery to remove organs- _____
- I am taking antibiotics currently
- I have taken cortisone/steroids in past 3 months
- I am pregnant, may be pregnant, or may become pregnant during trip

**I have had these medical problems:**

<input type="checkbox"/> diabetes	<input type="checkbox"/> lung disease
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> liver disease
<input type="checkbox"/> seizures	<input type="checkbox"/> heart disease
<input type="checkbox"/> psychosis	<input type="checkbox"/> asthma
<input type="checkbox"/> heart rhythm problems	
<input type="checkbox"/> prostate problems	
<input type="checkbox"/> cancer	<input type="checkbox"/> immune deficiency
<input type="checkbox"/> chemotherapy	<input type="checkbox"/> ulcers
<input type="checkbox"/> lymphoma	<input type="checkbox"/> bowel/kidney disease
<input type="checkbox"/> radiation therapy	

Please list drug allergies: _____

Please list current medications (Rx & OTC):  
 _____  
 _____

The information on the previous pages is correct and accurate. I request and consent to the administration of the vaccines to myself (or patient if legal guardian) agreed upon by myself and the certified pharmacists at Albers Medical Pharmacy.

I understand that I am financially responsible for all services rendered to me by the pharmacy staff at Albers Medical Pharmacy. I understand that Albers Pharmacy cannot bill my insurance and I am responsible for all submissions to my private insurance. By signing this waiver I understand that I am accepting financial responsibility for services rendered.

_____  
(signature)

____/____/_____  
(date)