

**SCREENING QUESTIONNAIRE FOR
ADULTS**

Last Name _____ First Name _____ Physician _____

Date of Birth _____ Age _____ Male / Female Race _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

SS# _____

Medical Insurance: _____ I have private insurance that:

- _____ pays for shots
- _____ covers some shots
- _____ covers shots but has a cap
- _____ does not pay for shots

- _____ Healthy Start/Medicaid
- _____ Unison
- _____ Buckeye
- _____ Caresource

_____ I have no insurance

Billing or MMIS # _____

Are you sick today? Yes No

Do you have allergies to eggs, yeast, streptomycin, neomycin, thimerosal, gelatin, or latex? Yes No

Have you ever had a serious reaction after receiving a vaccination? Yes No

Do you have cancer, leukemia, AIDS, or any other immune system problem? Yes No

Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? Yes No

Do you have a seizure, brain, or nerve problem? Yes No

During the past year have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? Yes No

Have you received any vaccinations in the past 4 weeks? Yes No

For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No

I have received a copy(s) of the Vaccine Information Statement(s) for each of the vaccine(s) I will receive today and I understand the risk and benefits of the vaccine(s). I grant permission for the Massillon City Health Department's Nursing Staff to administer the immunization(s). I authorize my Immunization Record to be released as needed to medical providers.

By signing this form, I also acknowledge that I have received or read a copy of the Notice of Privacy Practices.

Signature _____ Date _____

Reviewed by _____ Date _____

STAFF ONLY

DCL:

ADM:

Next scheduled appointment _____