GREENHILL PHARMACY

164 Parsippany Road Parsippany NJ 07054
Tel: 973.887.9444 • Fax: 973.887.3119
info@greenhillpharmacy.com

Patient Name: _____ Date of Birth: ____/____/____
(mm) (dd) (yr)

Medicare Claim Number: _____

Screening Questionnaire for Immunization

For adult patients to be vaccinated: 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 additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? ☐ YES ☐ NO
2. Does the person to be vaccinated have any allergies to medications, food, a vaccine component, or latex? ☐ YES ☐ NO
3. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination in the past? ☐ YES ☐ NO
4. Does the person have any long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? ☐ YES ☐ NO
5. Does the person have cancer, leukemia, AIDS, or any other immune system problem? ☐ YES ☐ NO
6. Does the person take cortisone, prednisone, other steroids, or anti-cancer drugs, or have you had radiation treatments? ☐ YES ☐ NO
7. Has the person had a seizure or a brain or other nervous system problem? ☐ YES ☐ NO
8. During the past year, has the person received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐ YES ☐ NO
9. For women: Is the person pregnant or is there a chance she could become pregnant during the next month? ☐ YES ☐ NO
10. Has the person received any vaccinations in the past 4 weeks? ☐ YES ☐ NO

Patient Signature : _____ Date: _____

To be completed by Pharmacist

Vaccine _____ Manufacturer & Lot Number _____

Administration Site ☐ Left Arm ☐ Right Arm

Dosage ☐ 0.5ml ☐ 2.5ml ☐ LAIV

Pharmacist's Signature _____ Date: _____