Massillon
City of Champions
Health Department

SCREENING QUESTIONNAIRE FOR ADULTS

Last Name _____ First Name _____ MI _____ Physician _____

Date of Birth _____ Age _____ Male / Female Race _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

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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

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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** _____

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STAFF ONLY **DCL:** **ADM:**

Next scheduled appointment _____