Health History for Adult/Child Immunizations

Client's Name:____ Date:_________________

If you are receiving vaccinations, answer these questions as they relate to you. If your child is receiving vaccinations, answer these questions as it relates to them.

1. ARE YOU (OR IS YOUR CHILD) SICK TODAY? ( ) YES ( ) NO
2. DO YOU (OR DOES YOUR CHILD) HAVE ALLERGIES TO MEDICATIONS, FOOD OR ANY VACCINE? ( ) YES ( ) NO
   If yes, please list the known allergies: ____
3. HAVE YOU (OR HAS YOUR CHILD) HAD A SERIOUS REACTION TO A VACCINE IN THE PAST? ( ) YES ( ) NO
4. DO YOU (OR DOES YOUR CHILD) HAVE CANCER, LEUKEMIA, SICKLE CELL, ASPLENIA, CHRONIC ILLNESS, AIDS, OR ANY OTHER IMMUNE SYSTEM PROBLEM? ( ) YES ( ) NO
5. HAVE YOU (OR HAS YOUR CHILD) HAD A SEIZURE OR A BRAIN PROBLEM? ( ) YES ( ) NO
6. HAVE YOU (OR HAS YOUR CHILD) TAKEN CORTIZONE, PREDNISONE, OTHER STERIODS (20 MG DAILY OR MORE), ANTICANCER DRUGS OR RADIATION TREATMENTS IN THE PAST 3 MONTHS? ( ) YES ( ) NO
7. HAVE YOU (OR HAS YOUR CHILD) RECEIVED A TRANSFUSION OF BLOOD OR PLASMA, OR BEEN GIVEN A MEDICINE CALLED IMMUNE (GAMMA) GLOBULIN IN THE PAST YEAR? ( ) YES ( ) NO
8. DO YOU (OR DOES YOUR CHILD) HAVE A BLEEDING DISORDER SUCH AS HEMOPHILIA OR THROMBOCYTOPENIA, OR ON ANTICOAGULANT THERAPY SUCH AS ASPIRIN THERAPY? ( ) YES ( ) NO

<u>Children Only:</u>

9. HAS YOUR CHILD RECEIVED VACCINES IN THE LAST 30 DAYS? ( ) YES ( ) NO
10. DOES YOU CHILD HAVE ASTHMA? ( ) YES ( ) NO

<u>Females only:</u>

11. ARE YOU (OR IS YOUR CHILD/TEEN) PREGNANT OR IS THERE A CHANCE YOU/SHE COULD BECOME PREGNANT IN THE NEXT 3 MONTHS? ( ) YES ( ) NO

<u>For children receiving vaccinations who are between the ages of 6 months – 6 years, please answer these additional questions below:</u>

1. IS YOUR CHILD LIVING IN OR REGULARLY VISITING, OR HAS YOUR CHILD LIVED IN OR REGULARLY VISITED, A HOUSE BUILT BEFORE 1978? ( ) YES ( ) NO
2. DOES YOUR CHILD HAVE A SIBLING OR PLAYMATE WHO HAS OR HAS HAD LEAD POISONING? ( ) YES ( ) NO
3. DOES YOUR CHILD FREQUENTLY COME IN CONTACT WITH AN ADULT WHO WORKS IN AN INDUSTRY OR HAS A HOBBY THAT USES LEAD (BATTERY FACTORY, STEEL SMELTER, OR STAINED GLASS)? ( ) YES ( ) NO
4. IS YOUR CHILD: (a) A RECENT IMMIGRANT; (b) A MEMBER OF A MINORITY; OR (c) ENROLLED IN HOOSIER HEALTHWISE? ( ) YES ( ) NO
5. DOES ANYONE IN YOUR FAMILY USE ETHNIC COSMETICS OR FOLK REMEDIES? ( ) YES ( ) NO
6. HAS YOUR CHILD BEEN TESTED FOR LEAD POISONING IN THE LAST TWELVE (12) MONTHS? ( ) YES ( ) NO

<u>For Office Use Only</u>
Referred for lead testing: ___________

Client/Parent/Guardian Signature: ____Date:___________________

Reviewed by: ____ Date:___________________