Today's Date: _____

Immunization Adult Health History

Last Name_____ First_____Middle_____

Address_____City_____State_____

Zip Code_____County_____ Sex **(circle)** M F Birth Date_____ Age_____

Phone Number _____ Doctor's Name____ _____

Race: Asian/Pacific Islander ☐ Black ☐ Native Am/Alaskan Native ☐ White ☐ Other ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐

Email Address: _____

Insurance Status:

Do you have medical insurance? Yes No If yes, name of insurance company_____

Can you afford to pay for vaccinations? Yes No

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1. Are you sick today? Yes _____ No _____
2. Are you allergic to any medicine? If yes, name the medication _____ Yes _____ No _____
3. Are you allergic to eggs or other foods? List _____ Yes _____ No _____
4. Do you have a history of serious or chronic illnesses? If yes, list names of illnesses on line below. Yes _____ No _____

   _____
5. Have you ever had a serious reaction after receiving a vaccine? If yes, which vaccine Yes _____ No _____

   _____
6. Have you ever been diagnosed with Guillain-Barre syndrome? Yes _____ No _____
7. Do you take medicine on a daily basis? List names of medications on line below: Yes _____ No _____

   _____
8. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem; or take large amounts of cortisone, prednisone, or other steroids? Yes _____ No _____
9. During the past year have you received a transfusion of blood or plasma, or been given immune globulin? Yes _____ No _____
10. **FOR WOMEN:** Are you pregnant or are you planning to become pregnant in the next three months? Yes _____ No _____

    Date of last menstrual period _____
11. Are you a household contact or caregiver of a child 0 through 59 months of age? Yes _____ No _____
12. Have you previously received immunizations at the Canton City Public Health? Yes _____ No _____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines and understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire one of these diseases. By signing this form, I acknowledge that I have received a copy of our Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history.

Signature of person to receive vaccine_____ Date_____

Form Reviewed by: _____ Date _____