# Patient Medical History and Consent Form

For Administrative Use Only:
Initial Vaccination: ☐
Revaccination: ☐ (Initial Patient Vaccination Number (PVN) _____)
Date: __/__/____ (mm/dd/yyyy)

*For Administrative Use Only:* Place Patient Vaccination Number (PVN) Sticker here

**Please fill out sections A, B, and D of this form. Please use ink and print.**

## SECTION A: PATIENT DEMOGRAPHIC INFORMATION

(To be filled out by the patient. Please use ink and print)

**Title**: _____ **First Name**: _____**Middle Name**_____
(Mr., Ms., Mrs., Dr., etc.)
**Last Name**: _____ **Suffix** (Jr. Sr., M.D., etc.): _____

**SSN:** _____-_____-_____ **Date of Birth:** ___/___/_____ (mm/dd/yyyy)

**Gender:** ☐ Male ☐ Female

**Street Address:**_____ **Apt. #:** _____

**City:** _____ **State:** _____ **Zip code:** _____

**County**_____

**Contact Information:**

Home Phone: (____) ____- _____ Work: (____) ____- _____ ext. _____

Cell Phone: (____) ____- _____ Fax: (____) ____- _____

E-Mail Address: _____

**Occupation**: _____ **Employer** _____

**Employer's Address** _____

Ethnicity/Race: ☐ Hispanic or Latino ☐ Asian ☐ African American ☐ Hawaiian
☐ American Indian or Alaskan ☐ White

**May we contact you in the future to discuss your vaccination experience?** ☐ Yes ☐ No

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## SECTION B: VACCINATION AND MEDICAL HISTORY

(To be filled out by the patient. Please use ink and print)

**Vaccination History**
**Did you ever receive the smallpox vaccine?** Use the most recent date if you were vaccinated more than once.
☐ I have documentation that I was vaccinated on this date: ___/___/_____ (mm/dd/yyyy)
☐ I recall that I was vaccinated on this date, but I don't have documentation: ___/___/_____ (mm/dd/yyyy)
☐ I was vaccinated in childhood, but I don't know the date.
☐ No, I was never vaccinated or I don't know.

**Do you have a vaccination scar?** ☐ Yes ☐ No or Don't Know
**Did you have any bad reactions to the vaccine (adverse events)?** ☐ Yes ☐ No or Don't know
If yes, please describe the reaction_____
_____



**Date:** __/__/____ (mm/dd/yyyy)

**Patient Name**: _____**PVN**:_____

**Medical History**
Have you received chickenpox (varicella) vaccination in the last month? ☐ Yes ☐ No
Are you currently taking medication? ☐ Yes ☐ No
If yes, please list medications:_____
_____
Are you sick today? ☐ Yes ☐ No
If yes, please describe your illness (you may need to wait to be vaccinated until you get better **)** _____
_____

**Do <u>YOU</u> have any of the following conditions?** Yes ☐ No ☐

1. Conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers, organ transplant, or agammaglobulinemia.
2. A severe autoimmune disease such as systemic lupus erythematosus (SLE) that may significantly suppress the immune system.
3. Currently taking, or have recently been treated with, immunosuppressive drugs like oral steroids (e.g. prednisone), some drugs for autoimmune disease, or drugs taken after an organ transplant.
4. Taking cancer treatment with drugs or radiation or have taken such treatment in the past three months.
5. Eczema or atopic dermatitis or a history of these conditions, even in childhood or infancy.
6. Other skin conditions that cause breaks in the skin such as an allergic rash, severe burn, impetigo, chickenpox, shingles, or severe acne.
7. Currently being treated with steroid eye drops.
8. Currently pregnant, breastfeeding, or planning to become pregnant in the next month.
9. Ever had a life-threatening allergic reaction to antibiotics polymixin B, streptomycin, chlortetracycline, neomycin or a previous dose of smallpox vaccine.

**IF YOU ANSWERED YES, YOU SHOULD NOT GET THE VACCINE AT THIS TIME.**

**Do any of your HOUSEHOLD MEMBERS OR CLOSE PHYSICAL CONTACTS have any of the following conditions?** Yes ☐ No ☐
(Close contacts include anyone living in your household and anyone you have close physical contact with, such as a sex partner. They do not include friends or co-workers.)

1. Conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers, organ transplant, or agammaglobulinemia.
2. A severe autoimmune disease such as systemic lupus erythematosus (SLE) that may significantly suppress the immune system.
3. Currently taking, or have recently been treated with, immunosuppressive drugs like oral steroids (e.g. prednisone), some drugs for autoimmune disease, or drugs taken after an organ transplant.
4. Taking cancer treatment with drugs or radiation or have taken such treatment in the past three months.
5. Eczema or atopic dermatitis or a history of these conditions, even in childhood or infancy.
6. Other skin conditions that cause breaks in the skin such as an allergic rash, severe burn, impetigo, chickenpox, shingles, or severe acne.
7. Currently pregnant or planning to become pregnant in the next month

**IF YOU ANSWERED YES, YOU SHOULD NOT GET THE VACCINE AT THIS TIME.**

*Screener comments/notes for clarification (for administrative use only)*_____
_____
_____

**SECTION C: CURRENT VACCINATION INFORMATION AND TAKE EVALUATION**

(This section will be filled in by clinic staff)

**Date:** __/__/____ (mm/dd/yyyy)

**Patient Name**: _____ **PVN**:_____

## DISPOSITION

☐ **Referred for Vaccination** ☐ **Deferred due to medical contraindications**

☐ **Vaccination refused**

Clinic personnel should pre-enter or attach this information before printing and copying the form.

| **Vaccination Clinic Information** | | **Vaccine Batch Information** | | | |
|---|---|---|---|---|---|
| **Name:** | | **Vaccine Type:** | | **Batch #:** | |
| **Contact:** | | **Program:** | | **Batch Date:** | |
| **Phone:** | | **Dilution Strength:** | | | |
| **Fax:** | | **Vaccine Lot#:** | | **Diluent Lot #:** | |
| **Address**: | | **Vaccine Lot Manufacturer:** | | **Diluent Lot Manufacturer:** | |

Referring Organization _____

Address _____

Date of Vaccination: ___/___/_____

Arm inoculated: ☐ Left ☐ Right

Vaccine Administered by: _____

(please enter first name, last name, and professional suffix (M.D., R.N., etc)

**Take Response**

**If take response evaluation is going to be conducted at another clinic site, please copy this page and send it to that location.**

Take Response Clinic:

Name _____

Address_____

Take Response Exam performed by:

_____

(please enter first name, last name, and professional suffix (M.D., R.N., etc)

Exam Date: ___/___/____

☐ Major

☐ Equivocal

☐ No Take

Additional Comments

**Adverse Events should be recorded in VAERS**

**SECTION D: CONSENT SIGNATURE**
**(TO BE RETAINED BY THE VACCINATION CLINIC)**

**Date:** __/__/____ (mm/dd/yyyy)
**Patient Name**: _____**PVN**:_____

I have:

- Received, read and understand the Smallpox Pre-Vaccination Information Package, including 1) the Vaccine Information Statement (VIS), 2) the VIS supplements (A-E) on reactions after smallpox vaccination, vaccination site appearance and care, skin conditions, weakened immune system, pregnancy and breastfeeding, and 3) the pre-event screening worksheet;
- Considered my own health status as well as the health status of my household members and close physical contacts;
- Had the opportunity to discuss my medical concerns with my healthcare provider or a health care provider at the vaccination clinic;
- Had the opportunity to obtain a referral to seek confidential laboratory testing for medical conditions that may increase my risk for adverse reactions from the vaccine;
- Responded to the questions above to the best of my ability.

**I understand the decision to be vaccinated is voluntary and agree to proceed with smallpox vaccination.**

_____ _____
Patient Signature Date

_____ _____
Medical Screener Date

Privacy Act Statement

The information requested on this form, including the Social Security Number (SSN), is collected under the authority of Section 311 of the Public Health Service Act (42 U.S.C. 243), the NCVIA (42 U.S.C. 300aa-2(a)), and Section 304 of the Homeland Security Act of 2002 (Pub. L. No. 107-296). The information will be used in the analysis and follow-up of significant events associated with smallpox vaccination and to assure availability of smallpox response teams. The SSN is being collected for identity verification purposes. Furnishing the requested information, including SSN, is voluntary; however, with more complete information, public health objectives, such as adequate monitoring and follow-up of potential adverse events, are more readily achievable. Identifiable information may be shared with authorized U.S. Department of Health & Human Services' personnel and public health or cooperating medical authorities.



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