

**SCREENING QUESTIONNAIRE FOR  
ADULTS**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male / Female \_\_\_\_\_ Race \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Print Name of Legal Guardian, if applicable \_\_\_\_\_ SS# \_\_\_\_\_

**Do you have insurance?** **Yes** **No**

Name of Primary Medical Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Plan \_\_\_\_\_ MMIS# \_\_\_\_\_

Does insurance pay for some immunizations? Yes No Don't Know

Does it pay for all immunizations? Yes No Don't Know

Covers immunizations, but has a cap Yes No Don't Know

**Name of Secondary Medical Insurance** \_\_\_\_\_

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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** \_\_\_\_\_