Screening Questionnaire for Adult Immunization

Wyoming Department of Health

Client Name _____

DOB __ /__ /__ Male ☐ Female ☐

Mailing Address _____
City State Zip

Phone Number _____

Are you a Wyoming Resident? Yes ☐ No ☐

Do you have health insurance? Yes ☐ No ☐

If yes, does insurance cover the cost of vaccine? Yes ☐ No ☐

	Yes	No	Unsure
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? If yes, please list: _____	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal f1uid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 months. have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	☐	☐	☐
13. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

By signing below, I give my consent to be given all current immunizations appropriate for me. I have read the Vaccine Information Statement(s) for the vaccine(s) to be given today. A health care professional has provided education and counseling on each vaccine, and I have had a chance to ask questions that were answered to my satisfaction.

Client Signature _____ Date _____

Witness _____