Vaccination Pre-Screening Questions

Please respond to the following COVID-19 screening questions. If you respond "Yes" to any of these questions, please let the Pharmacy Team know prior to filling out the remainder of the form.

Have you had any of the following symptoms in the last 14 days?
O fever O cough O shortness of breath O fatigue O muscle pains O headache O new loss of taste or smell O sore throat O congestion or runny nose O nausea or vomiting O diarrhea

Have you had close contact with or cared for a person with confirmed or presumed COVID-19 in the last 14 days? O **Yes** O **No**

Have you tested positive for COVID-19 in the last 14 days? O **Yes** O **No**

Please check requested vaccine(s): O **Flu** O **Pneumonia** O **Shingles** O **Pertussis** O **Other** _____

Previous Pharmacy Customers: Please fill out the information shaded in **GRAY**.

New Pharmacy Customers: Please fill out **ALL** of the information.

Patient Name (Printed)	DOB	Age	Sex	Date

Address	City	State	Zip Code	Phone

Primary Care Provider Name	Primary Care Provider City	O I do not have a Primary Care Provider

Allergies

Insurance ID	Insurance BIN	Insurance PCN	Insurance GRPP

Emergency Contact Name	Emergency Contact Phone

New York only: I opt in to reporting my vaccination information to the immunization registry in my state.
O **N/A** O **Yes** O **No**

Massachusetts only: I was informed that my vaccination information will be reported to the immunization registry in my state.
O **N/A** O **Yes** O **No**

Are you sick and/or have a fever today? O **Yes** O **No**

Are you pregnant, nursing, or plan to become pregnant within 4 weeks of vaccination? O **Yes** O **No**

Have you ever had a serious reaction after receiving a vaccine? O **Yes** O **No**

Have you received any vaccines in the past 4 weeks? O **Yes** O **No**

Have you ever received any of the following vaccinations? (Check all that apply) O **Flu** O **Zostavax** O **Shingrix** O **Pneumovax** O **Prevnar**

Do you have any allergies to medications, food, thimerosal, or vaccine ingredient? O **Yes** O **No**

Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or blood disorder? O **Yes** O **No**

Do you have cancer, leukemia, AIDS, or any other immune system problem? O **Yes** O **No**

Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? O **Yes** O **No**

Have you had a seizure, brain, or other nervous system problem such as Guillain-Barre syndrome? O **Yes** O **No**

During the past year have you received a transfusion of blood or blood products or been given immune (gamma) globulin? O **Yes** O **No**