CENTRAL DISTRICT HEALTH DEPARTMENT

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

Medical History

Patient # _____

Client Name _____ **Client DOB** _____

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it.	***PLEASE MARK ANSWER***		
Is the patient sick today?	☐ YES	☐ NO	☐ NOT SURE
Does the patient have any known allergies to medications, food, vaccine component or latex? (For example: eggs) Please list: _____	☐ YES	☐ NO	☐ NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	☐ YES	☐ NO	☐ NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	☐ YES	☐ NO	☐ NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐ YES	☐ NO	☐ NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had radiation treatments? Long term aspirin therapy? Daily aspirin dose _____.	☐ YES	☐ NO	☐ NOT SURE
During the **past year**, has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	☐ YES	☐ NO	☐ NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the **past four weeks**? If yes, when? month _____ day _____	☐ YES	☐ NO	☐ NOT SURE
Does the patient have any of the following: asthma, wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Is the patient on long-term aspirin therapy?	☐ YES	☐ NO	☐ NOT SURE
Has the patient had chickenpox? If yes, when? _____	☐ YES	☐ NO	☐ NOT SURE
Does your family have a dentist?	☐ YES	☐ NO	☐ NOT SURE
Has your child seen a dentist in the last year?	☐ YES	☐ NO	☐ NOT SURE
For females: Are you pregnant or is there a chance you could become pregnant during the next month?	☐ YES	☐ NO	☐ NOT SURE

I have received the vaccine information statement (s) for vaccines being administered today.

☐ **I GIVE CONSENT -** To CDHD and staff to administer the recommended vaccines to my child / self.

☐ **I CHOOSE NOT** to have my child /self vaccinated with the following: DTaP / Flu / Hep A / Hep B / HIB / HPV / Meningitis / MMR / PCV 13 / Polio / Rotavirus / Tdap / Varicella

☐ My child / self will return to CDHD for immunizations or ☐ My child /self will return to our physician for immunizations

Signature of person completing form: _____ **Date:** _____ **Nurse:**_____