

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Screening Form Page 1 of 2
To be completed by potential vaccine recipient

1. Today's Date (dd/mm/yyyy): _____
2. GENDER: Male Female
3. Have you ever received the smallpox vaccine? Yes No Unsure
4. Have you ever had a serious problem after smallpox or other vaccination? Yes No Unsure
 If YES; Explain: _____
5. Do you have a current illness with fever? Yes No Unsure
6. Are you allergic to any of these products: polymyxin B, neomycin? Yes No Unsure
7. Are you being treated with eye drops or ointment? Yes No Unsure
8. Are you recovering from a recent surgery (including eye or dental)? Yes No Unsure
9. Could YOU or someone you LIVE WITH be pregnant? Yes No Unsure
10. Do you have a child in the home less than one year of age? Yes No Unsure
11. Are you currently breastfeeding? Yes No N/A
12. Do you have a heart or blood vessel condition, such as angina, earlier heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, stroke, mini stroke, chest pain or shortness of breath on exertion or history of significant arrhythmia with or without corrective/ablative surgery? Yes No Unsure
13. Check EACH of the following conditions that apply to you: Smoke cigarettes now High blood pressure High cholesterol
 Diabetes or high blood sugar Heart condition before age 50 in mother, father, brother, sister
14. Are you currently taking any prescription medications for your blood pressure, cholesterol, or diabetes? Yes No Unsure

Before vaccinating against smallpox, we want to know if YOU or YOUR HOUSEHOLD CONTACTS have any of several medical conditions.

Please answer the following questions to the best of your knowledge.

	Myself	Close Contact
15. Do you OR someone you currently live with NOW HAVE any of the following skin problems: psoriasis, skin infection, uncontrolled acne, shingles, chickenpox, burns, recent tattoo, recent piercing, or other conditions causing breaks in the skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
16a. Do you OR someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For example: have or take medication for HIV, AIDS, leukemia, lymphoma, chronic liver problem, Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medications for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
16b. Are you concerned that you might have one or more risk factors for HIV? NOTE: If you think you might have an increased risk for HIV infection, HIV testing is available.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
17a. Have you OR someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes). If YES or UNSURE for either you or your close contact, answer 17b-17f.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
17b. A doctor has made the diagnosis of eczema or atopic dermatitis.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
17c. There have been (dry) scaly, itchy rashes that have lasted more than 2 weeks.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
17d. At least once, there is a history of an itchy rash in the folds of the arms or legs.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
17e. There is a history of eczema and food allergy during childhood.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
17f. A doctor has made the diagnosis of asthma or hay fever (including parents, brothers, or sisters).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

"FOR FEMALES ONLY:" If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

18a. First day of last menstrual period: _____ 18b. Was your last menstrual period normal and on time? Yes No Unsure

19. Do you have other questions or have other concerns you would like to discuss? Yes No

Explain "other," "unsure" or additional concerns (may use additional page): _____

PATIENT'S IDENTIFICATION (May use for mechanical imprint):

RECORDS MAINTAINED AT:

LAST NAME:

RANK/GRADE:

FIRST NAME:

STATUS:

FMP/SSAN:

DEPT/SVS:

DATE OF BIRTH:

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Screening Form Page 2 of 2
To be completed by a healthcare provider

1. Provider Assessment Date (dd/mm/yyyy): _____

(Note: If provider Assessment Date or Action Taken Immunization Date is blank, the Default date is "Today's Date" on page 1.)

2. Vaccine risk factors based on page 1 review and patient interview (check all that apply):

	Self	Close Contact
No restriction	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Immune suppression	<input type="checkbox"/>	<input type="checkbox"/>
Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Infant under 1 year old	<input type="checkbox"/>	
Heart condition	<input type="checkbox"/>	3+ RF <input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/> (Describe in #4)

3. Provider decision and plan, check all that apply:

- Vaccinate: Primary Vaccinate: Revaccination Do Not vaccinate; current within 10 yr interval
- Vaccination exemption; medical permanent (MP) (note in section #4)
- Vaccination exemption; medical temporary (MT); (see #2 above or note in section #4):

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevant diagnosis:

Credentialed Provider Signature and Printed Name/Stamp:

VACCINE ADMINISTRATION: Vaccination Date (dd/mm/yyyy): _____

6. Location: Left Arm (15 jabs) Right Arm (15 jabs) Other location (describe):

CIRCLE LOT# ADMINISTERED: Lot #: **VV03-019-C** OR **U3913DA** MFR: **sanofi-pasteur**

7. **IF IMMUNIZED**, check all that apply:

- Medication Guide given to patient Bandages provided if needed Females advised to avoid becoming pregnant for 4 weeks
- Patient advised about post-vaccination reaction, site care, and reasons for follow-up visit Patient understands information provided

Please assure that all actions taken and deferrals are updated into your Service's Immunization Tracking System (ITS) as soon as possible.

Vaccine administered by: (Signature and Printed Name/Stamp)

PATIENT'S IDENTIFICATION (May use for mechanical imprint):

RECORDS MAINTAINED AT:

LAST NAME:

RANK/GRADE:

FIRST NAME:

STATUS:

FMP/SSAN:

DEPT/SVS:

DATE OF BIRTH: