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?	□ Yes □ No □ Unsure	□ Yes □ No □ 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.	□ Yes □ No □ Unsure	□ Yes □ No □ 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.	□ Yes □ No □ 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.	□ Yes □ No □ Unsure	□ Yes □ No □ Unsure
17b. A doctor has made the diagnosis of eczema or atopic dermatitis.	□ Yes □ No □ Unsure	□ Yes □ No □ Unsure
17c. There have been (dry) scaly, itchy rashes that have lasted more than 2 weeks.	□ Yes □ No □ Unsure	□ Yes □ No □ Unsure
17d. At least once, there is a history of an itchy rash in the folds of the arms or legs.	□ Yes □ No □ Unsure	□ Yes □ No □ Unsure
17e. There is a history of eczema and food allergy during childhood.	□ Yes □ No □ Unsure	□ Yes □ No □ Unsure
17f. A doctor has made the diagnosis of asthma or hay fever (including parents, brothers, or sisters).	□ Yes □ No □ Unsure	□ Yes □ No □ 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	☐	☐
Pregnancy	☐	☐
Immune suppression	☐	☐
Skin condition	☐	☐
Infant under 1 year old	☐	
Heart condition	☐ 3+ RF ☐	
Other	☐	☐ (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:

5. Vaccination Date (dd/mm/yyyy): _____

6. Dose: 15 jabs/0.0025 mL Location: ☐ Left Arm ☐ Right Arm ☐ Other (describe):

7. Lot # administered (circle): **VV03-019-C, U3913DA, U3913EA,** OR **U5722AAA**

   Manufacturer: sanofi-pasteur

8. **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: