

## Patient Medical History and Consent Form

For Administrative Use Only:

Initial Vaccination:

Revaccination:  (Initial Patient Vaccination Number (PVN) \_\_\_\_\_)

Date: \_\_/\_\_/\_\_\_\_ (mm/dd/yyyy)

For Administrative Use Only: Place  
Patient Vaccination Number (PVN)  
Sticker here

Please fill out sections A, B, and D of this form. Please use ink and print.

### SECTION A: PATIENT DEMOGRAPHIC INFORMATION

(To be filled out by the patient. Please use ink and print)

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name \_\_\_\_\_

(Mr., Ms., Mrs., Dr., etc.)

Last Name: \_\_\_\_\_ Suffix (Jr. Sr., M.D., etc.): \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_ (mm/dd/yyyy)

Gender:  Male  Female

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

County \_\_\_\_\_

#### Contact Information:

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext. \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Ethnicity/Race:  Hispanic or Latino  Asian  African American  Hawaiian

American Indian or Alaskan  White

May we contact you in the future?  Yes  No

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### SECTION B: VACCINATION AND MEDICAL HISTORY

(To be filled out by the patient. Please use ink and print)

#### Vaccination History

**Did you ever receive the smallpox vaccine?** Use the most recent date if you were vaccinated more than once.

I have documentation that I was vaccinated on this date: \_\_/\_\_/\_\_\_\_ (mm/dd/yyyy)

I recall that I was vaccinated on this date, but I don't have documentation: \_\_/\_\_/\_\_\_\_ (mm/dd/yyyy)

I was vaccinated in childhood, but I don't know the date.

No, I was never vaccinated or I don't know.

**Do you have a vaccination scar?**  Yes  No or Don't Know

**Did you have any bad reactions to the vaccine (adverse events)?**  Yes  No or Don't know

If yes, please describe the reaction \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Patient Name: \_\_\_\_\_ PVN: \_\_\_\_\_

### Medical History

Have you received chickenpox (varicella) vaccination in the last month?  Yes  No

Are you currently taking medication?  Yes  No

If yes, please list medications: \_\_\_\_\_

Are you sick today?  Yes  No

If yes, please describe your illness (you may need to wait to be vaccinated until you get better )

\_\_\_\_\_

Do any of the following apply to YOU? Yes  No

1. Do you have any conditions that weaken the immune system such as HIV/AIDS; leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?
2. Do you have a severe autoimmune disease such as lupus that may weaken the immune system?
3. Are you now taking, or have you recently taken, drugs that can weaken the immune system like steroids (e.g. prednisone), medicines for autoimmune disease, or medicines taken after an organ transplant?
4. Are you now taking cancer treatment with drugs or radiation or have you taken such treatment in the past 3 months?
5. Do you now have, or have you ever had eczema or atopic dermatitis (even as a baby or child and even if the condition is mild)?
6. Do you now have other skin problems that have made many breaks in your skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, or severe acne?
7. Are you now being treated with steroid eye drops?
8. Are you pregnant, breastfeeding, or planning to become pregnant in the next month?
9. Have you ever had a life-threatening allergic reaction to smallpox vaccine, latex or the antibiotics polymixin B, streptomycin, chlortetracycline, or neomycin?
10. Have you ever been diagnosed by a doctor as having heart disease with or without symptoms such as previous myocardial infarction (heart attack), angina (chest pain caused by lack of blood flow to the heart), congestive heart failure, or cardiomyopathy?
11. Have you ever had a stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)?
12. Do you have chest pain or shortness of breath when you exert yourself (such as when you walk up stairs)?
13. Do you have any other heart condition for which you are under the care of a doctor?
14. Do you have three or more of the following risk factors?
  - a. You have been told by a doctor that you have high blood pressure.
  - b. You have been told by a doctor that you have high blood cholesterol.
  - c. You have been told by a doctor that you have diabetes or high blood sugar.
  - d. You have a first degree relative (for example mother, father, brother, or sister) who had a heart condition before the age of 50.
  - e. You smoke cigarettes now.

**IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE,  
YOU SHOULD NOT GET THE SMALLPOX VACCINE AT THIS TIME.**

(Continues on next page)

Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Patient Name: \_\_\_\_\_ PVN: \_\_\_\_\_

Do any of the following apply to your **CLOSE CONTACTS**? Yes  No

(A close contact is someone you live with or have close physical contact with, such as a sex partner. Close contacts do not include friends or co-workers.)

1. Do any of your close contacts have conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?
2. Do any of your close contacts have a severe autoimmune disease such as lupus that may weaken the immune system?
3. Are any of your close contacts now taking, or have they recently taken, drugs that can weaken the immune system like steroids (e.g. prednisone), medicines for autoimmune disease, or medicines taken after an organ transplant?
4. Are any of your close contacts taking cancer treatment with drugs or radiation or have they taken such treatment in the past 3 months?
5. Do any of your close contacts now have, or have they ever had eczema or atopic dermatitis (even as a baby or child and even if the condition is mild)?
6. Do any of your close contacts now have other skin problems that have made many breaks in their skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, severe diaper rash, or severe acne?
7. Are any of your close contacts pregnant or planning to become pregnant in the next month?

**IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE,  
YOU SHOULD NOT GET THE SMALLPOX VACCINE AT THIS TIME.**

<p><i>Screener comments/notes for clarification (for administrative use only)</i> _____</p> <p>_____</p> <p>_____</p>
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**SECTION C: CURRENT VACCINATION INFORMATION AND TAKE EVALUATION**

(This section will be filled in by clinic staff)

Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Patient Name: \_\_\_\_\_ PVN: \_\_\_\_\_

**DISPOSITION**

<input type="checkbox"/> <b>Referred for Vaccination</b>	<input type="checkbox"/> <b>Deferred due to medical contraindications</b>
<input type="checkbox"/> <b>Vaccination refused</b>	

Clinic personnel should pre-enter or attach this information before printing and copying the form.

Vaccination Clinic Information		Vaccine Batch Information			
Name:		Vaccine Type:		Batch #:	
Contact:		Program:		Batch Date:	
Phone:		Dilution Strength:			
Fax:		Vaccine Lot#:		Diluent Lot #:	
Address:		Vaccine Lot Manufacturer:		Diluent Lot Manufacturer:	

Referring Organization _____ Address _____  Date of Vaccination: ___/___/___  Arm inoculated: <input type="checkbox"/> Left <input type="checkbox"/> Right  Vaccine Administered by: _____ (please enter first name, last name, and professional suffix (M.D., R.N., etc))
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**Take Response**

**If take response evaluation is going to be conducted at another clinic site, please copy this page and send it to that location.**

Take Response Clinic: Name _____ Address _____ Take Response Exam performed by: _____ (please enter first name, last name, and professional suffix (M.D., R.N., etc))	Exam Date: ___/___/___ <input type="checkbox"/> Major <input type="checkbox"/> Equivocal <input type="checkbox"/> No Take
Additional Comments	

**Adverse Events should be recorded in VAERS**

**SECTION D: CONSENT SIGNATURE  
(TO BE RETAINED BY THE VACCINATION CLINIC)**

**Date:** \_\_/\_\_/\_\_\_\_ (mm/dd/yyyy)

**Patient Name:** \_\_\_\_\_ **PVN:** \_\_\_\_\_

I have:

- received, read and understand the Smallpox Pre-Vaccination Information Package, including 1) the Vaccine Information Statement (VIS), 2) the VIS supplements (A-E) on reactions after smallpox vaccination, vaccination site appearance and care, skin conditions, weakened immune system, pregnancy and breastfeeding, 3) the March 31, 2003 VIS supplement on smallpox vaccine and heart problems, and 4) the pre-event screening worksheet;
- considered my own health status as well as the health status of my household members and close physical contacts;
- had the opportunity to discuss my medical concerns with my health care provider or a health care provider at the vaccination clinic;
- had the opportunity to obtain a referral to seek confidential laboratory testing for medical conditions that may increase my risk for adverse reactions from the vaccine;
- responded to the questions above to the best of my ability.

**I understand the decision to be vaccinated is voluntary and agree to proceed with smallpox vaccination.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Screener

\_\_\_\_\_  
Date

**Privacy Act Statement**

The information requested on this form, including the Social Security Number (SSN), is collected under the authority of Section 311 of the Public Health Service Act (42 U.S.C. 243), the NCVIA (42 U.S.C. 300aa-2(a)), and Section 304 of the Homeland Security Act of 2002 (Pub. L. No. 107-296). The information will be used in the analysis and follow-up of significant events associated with smallpox vaccination and to assure availability of smallpox response teams. The SSN is being collected for identity verification purposes. Furnishing the requested information, including SSN, is voluntary; however, with more complete information, public health objectives, such as adequate monitoring and follow-up of potential adverse events, are more readily achievable. Identifiable information may be shared with authorized U.S. Department of Health & Human Services' personnel and public health or cooperating medical authorities.