PEPPERDINE
UNIVERSITY
Student Health Center

Immunization Screening Questions

Name: _____

		Yes	No
1.	Are you sick today or do you have a high fever?		
2.	Have you ever had a reaction to an immunization, which was so bad that you had to go to a doctor or hospital, or had a high fever after receiving an immunization?	☐	☐
3.	Are you taking a drug that lowers your resistance to infection (such as Prednisone, or other steroids, anti-cancer treatment or radiation) or are you on any anti-viral medications?	☐	☐
4.	Do you have cancer, leukemia, AIDS, thymus disease or removal, or any other immune system problems?	☐	☐
5.	Have you had an allergic reaction to latex, eggs, neomycin, streptomycin, Baker's yeast, polymyxin B, gelatin, thimerosal, or foods that required medical treatment?	☐	☐
6.	Have you had a blood transfusion or gamma globulin in the past year? Date:_____	☐	☐
7.	Have you ever had a positive tuberculosis skin test?	☐	☐
8.	Have you had Guillain-Barre Syndrome, a serious neurological disorder involving increasing weakness in the legs and arms that can be severe?	☐	☐
9.	Do you have a bleeding disorder or are you taking anti-coagulation? (Coumadin)	☐	☐
10.	Do you have a long-term health problem i.e. heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?	☐	☐
11.	Females requesting immunization: Date of last menstrual period:_____ Are you nursing, is there a chance you may be pregnant or do you intend to become pregnant in the next three months?	☐	☐

_____ _____ ____/____/____

Patient's Signature ID# Date

Did you bring your immunization record card with you? ☐ Yes ☐ No

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.