

**ADULT HEALTH HISTORY
IMMUNIZATIONS**

PRINT YOUR LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ BIRTHDATE _____ AGE _____ RACE _____ SEX _____

DOCTOR'S NAME _____

Insurance Status:

- | | |
|---|--|
| <input type="checkbox"/> I have Caresource # _____ | <input type="checkbox"/> I have private insurance that covers the cost of shots 100% |
| <input type="checkbox"/> I have Buckeye # _____ | <input type="checkbox"/> I have private insurance that does not cover shots 100% |
| <input type="checkbox"/> I have United Healthcare # _____ | <input type="checkbox"/> I do not have any insurance |
| <input type="checkbox"/> I have Medicaid # _____ | |

- Are you sick today? Yes ___ No ___

- Are you allergic to any medicine? If yes, name the medication _____ Yes ___ No ___

- Are you allergic to eggs or other foods? List _____ Yes ___ No ___

- Do you have a history of serious illness? If yes, list names of illnesses on line below. Yes ___ No ___

- Have you ever had a serious reaction after receiving a vaccine? If yes, which vaccine Yes ___ No ___

- Do you take medicine on a daily basis? List names of medications on line below: Yes ___ No ___

- Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem; or take large amounts of cortisone, prednisone, or other steroids? Yes ___ No ___

- During the past year have you received a transfusion of blood or plasma, or been given immune globulin? Yes ___ No ___

- **FOR WOMEN:** Are you pregnant or are you planning to become pregnant in the next three months? Yes ___ No ___
Date of last menstrual period _____

- Have you previously received immunizations at the Canton City Health Department? Yes ___ No ___

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines and understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire one of these diseases. By signing this form, I acknowledge that I have received a copy of our Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history.

Signature of person to receive vaccine _____

Date _____