ADULT HEALTH HISTORY
IMMUNIZATIONS

Last Name___________________________________ First_________________________________Middle__________________

Address____City______________________State________________

Zip Code_______________County_____________________ Sex **(circle)** M F Birth Date____________ Age________

Phone Number _______________________________________ Doctor's Name____

Race: Asian/Pacific Islander ☐ Black ☐ Native Am/Alaskan Native ☐ White ☐ Other ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐

Email Address: ____

Insurance Status:

Do you have medical insurance? Yes No

Can you afford to pay for vaccinations? Yes No

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1. Are you sick today? Yes ______ No ______
2. Are you allergic to any medicine? If yes, name the medication _________________________ Yes ______ No ______
3. Are you allergic to eggs or other foods? List ____ Yes ______ No ______
4. Do you have a history of serious or chronic illnesses? If yes, list names of illnesses on line below. Yes ______ No ______

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5. Have you ever had a serious reaction after receiving a vaccine? If yes, which vaccine Yes ______ No ______

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6. Have you ever been diagnosed with Guillain-Barre syndrome? Yes ______ No ______
7. Do you take medicine on a daily basis? List names of medications on line below: Yes ______ No ______

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8. 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 ______
9. During the past year have you received a transfusion of blood or plasma, or been given immune globulin? Yes ______ No ______
10. **FOR WOMEN:** Are you pregnant or are you planning to become pregnant in the next three months? Yes ______ No ______

    Date of last menstrual period ______________________________

11. Are you a household contact or caregiver of a child 0 through 59 months of age? Yes ______ No ______
12. 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____________________