Today's Date: _____

Immunization Adult Health History

Public Health
Prevent. Promote. Protect.
Canton City Public Health

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 If yes, name of insurance company_____

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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 _____

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

   _____
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 _____

   _____
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 Public Health? Yes _____ No _____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines. I 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 this disease. By signing this form, I also acknowledge that I have received a copy of Canton City Public Health's Notice of Privacy Practices. I also grant permission for this record to be released to the immunization registry and provided to medical providers, health departments and schools to transmit the immunization history.

Signature of person to receive vaccine_____ Date _____

Form Reviewed by: _____ Date _____