PUBLIC HEALTH
Prevent • Promote • Protect
BENTON-FRANKLIN HEALTH DISTRICT

CLINIC SCREENING

Patient Name:_____ **Date of Birth:**_____

Answering the following questions will help us provide better care for you. If a question is not clear, please ask the nurse to explain it.

	Yes	No
1. Is the client sick today?	☐	☐
2. Does client have an allergy to medications, food, a vaccine component or latex?	☐	☐
3. Has the client had a serious reaction to a vaccine in the past?	☐	☐
4. Does client have a health problem with lung, heart, kidney/metabolic disease, asthma, or blood disorder?	☐	☐
5. If the client is a baby, have you ever been told he/she has had intussusception?	☐	☐
6. If the client to be vaccinated is 2 – 4 years of age, has a health care provider told you that your child has wheezing or asthma in the past 12 months?	☐	☐
7. Has the client, sibling or parent had seizure, brain or other nervous system problems?	☐	☐
8. Does client have problems with his/her immune system such as cancer, leukemia, HIV/AIDS?	☐	☐
9. In the last three months, has the client taken medications that affect their immune system such as prednisone, other steroids or anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis or radiation treatment?	☐	☐
10. In the past year, has the client received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
11. Is the client pregnant or is there a chance she could become pregnant during the next month?	☐	☐
12. Has the client received vaccinations in the past 4 weeks?	☐	☐
13. If you have private insurance, does it cover immunizations?	☐	☐
14. Is your child American Indian or Alaskan Native?	☐	☐
15. Is your child covered by private insurance?	☐	☐
16. Is your child covered by Medicaid/Apple Health?	☐	☐
17. Is your child covered by medical insurance of any kind?	☐	☐

Did you bring your immunization record with you? **Yes** **No**

Form completed by: _____Form reviewed by: _____

Notes

BP		
Weight		
Temp		