

ALVARADO MEDICAL PLAZA PHARMACY

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SCREENING QUESTIONNAIRE FOR HEPATITIS-B VACCINATION

Patient Name: _____

Assessment Date:

____/____/20____

Weight ____ (lbs) ____ (kgs)

Date of Birth: ____/____/____

PATIENTS: The following questions will help us determine if the Hepatitis-B vaccine is appropriate to administer to you today. If a question is not clear, please ask the Pharmacist to further explain

| | YES | NO | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| 1. Are you ill (sick) today | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you received a Hepatitis-B shot in the past If yes, do you remember when (best estimate date ____/____/____) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If you had a Hepatitis-B shot in the past, did you have a serious allergic reaction after receiving a vaccination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware that Hepatitis-B Vaccine is a "three-series" shot (e.g. first not now, second shot (booster) in 1 month and the final third shot (booster in 6 months) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you allergic to any medications or foods? (If so please list) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you <input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. FOR WOMEN: Are you pregnant or is there a chance you could become pregnant in the next three months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I have read, or have had explained to me, the question listed above. I have had the opportunity to ask questions that were answered to my satisfaction. I have read and been provided the current Hepatitis-B VIS (Vaccination Information Statement) published by the CDC. I understand the benefits and risks of the vaccination cited and request this vaccination to be administered intramuscularly to myself or the person listed above (for whom I am authorized to make this request). For first time vaccinations, I understand that it is essential that I remain on location for approximately 15 (fifteen) minutes following administration.

Form consent/completed by: _____ Date: ____/____/20____

---OFFICE USE ONLY---

Vaccination Administered by: _____

Did the patient experience any reaction? YES NO