

ALVARADO MEDICAL PLAZA PHARMACY

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SCREENING QUESTIONNAIRE FOR ZOSTAVAX (VZV) VACCINATION

Patient Name: _____

Assessment Date:
____/____/20____

Weight ____ (lbs) ____ (kgs)

Date of Birth: ____/____/____

PATIENTS: The following questions will help us determine if the Zostavax (VZV) 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 sixty (60) years of age or older? (<i>Zostavax is only approved for individuals 60 years of age or older.</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been previously diagnosed with shingle? (<i>Zostavax is not for persons who have or have had shingles.</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you ill (sick) today? (<i>Do you have a temperature of 101.3 degrees or higher?</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious allergic reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you allergic to gelatin or neomycin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have HIV/AIDs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you currently being treated with drugs that affect the immune system, such as steroids (<i>e.g. Prednisone or any other Corticosteroids?</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you currently being treated for cancer and receiving radiation or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a history of cancer affecting the bone marrow or lymphatic system, such as Leukemia or Lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have active or untreated tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past year have you received a transfusion of blood, blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you <input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. 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 Zostavax (VZV) 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