SMALLPOX VACCINATION
PATIENT MEDICAL HISTORY AND CONSENT FORM

For Clinic Use Only:

Initial Vaccination: ☐
Revaccination: ☐ (Initial PVN _____)
Date: ____/____/____
mm dd yyyy

Place Patient Vaccination Number (PVN) sticker here

PATIENT MUST COMPLETE SECTIONS A, B, C, D, E and F. Please use pen and print.

SECTION A GENERAL PATIENT INFORMATION

Title: _____ First Name: _____ Middle Name: _____
(Mr., Ms., Mrs., Dr., etc.)

Last Name: _____ Suffix: _____
(Jr., Sr., MD., etc.)

Social Security Number (optional): ____/____/____

†*Date of Birth* (year is required): ____/____/____ Gender: ☐ Male ☐ Female
mm dd yyyy

Street Address: _____ Apt. #: _____

City: _____ State: _____

Zip code: _____ County: _____

Your Contact Information:

Home Phone: (_____) _____ - _____ Work: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Beeper/Pager: (_____) _____ - _____ Beeper/Pager PIN #: _____

E-mail Address: _____

Occupation: _____

Ethnicity/Race (optional, you do not have to provide this information. If you choose to provide this information, you may select more than one category):

☐ Hispanic or Latino Ethnicity ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ White

†*Did you serve in the military before 1984?* ☐ Yes ☐ No

SECTION B PATIENT VACCINATION HISTORY

How many times have you already received smallpox vaccination? Do NOT count smallpox vaccinations you received since January 2003 as part of the National Smallpox Vaccination Program (NSVP)

☐ 0 ☐ 1 ☐ 2 ☐ More than 2 ☐ Don't know

Enter the year of the **most recent** vaccination prior to the NSVP if known: _____

†*Please indicate source of date*: ☐ Document (e.g., vaccination card) ☐ self-recall (from memory)

If year of your **most recent** vaccination prior to the NSVP is unknown: (check one)

☐ I was vaccinated in childhood but can't recall the date

☐ I was vaccinated in adulthood but can't recall the date

Have you been told (for instance, by a doctor or a parent) that your vaccination was successful?

☐ Yes ☐ No ☐ Don't Know

Do you have a vaccination scar? ☐ Yes ☐ No ☐ Don't Know

Did you have any bad reaction(s) to the vaccine? ☐ Yes ☐ No ☐ Don't know

If yes, you should not get the vaccine at this time if the reaction(s) was serious.
Please tell us about the reaction(s) _____

Date: _____ mm dd yyyy

Patient Name: _____ **PVN:** _____

SECTION C PATIENT CONTACT AFTER VACCINATION

During the month following vaccination, you may be contacted for routine follow-up.
May we also contact you in the future about participating in a survey? ☐ Yes ☐ No

SECTION D REFERRING ORGANIZATION

Please provide the following information about the organization that referred you for vaccination.

Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

County: _____ Phone: (_____) _____ - _____

SECTION E PATIENT MEDICAL HISTORY

Have you received chickenpox (varicella) vaccination in the last month? ☐ Yes ☐ No
If yes, you should not get the smallpox vaccine at this time.

Are you currently taking medication? ☐ Yes ☐ No
If yes, please list medications (also see questions 3, 4, and 17 below):

_____

Are you sick today? ☐ Yes ☐ No
If yes, please describe your illness, you may need to wait to get the vaccine

_____

Do any of the following apply to <u>YOU</u>? ☐ Yes ☐ No

Weakened Immune System

1. Do you have any conditions that weaken the immune system such as HIV/AIDS; leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?
2. Do you have a severe autoimmune disease such as lupus that may weaken the immune system?
3. Are you now taking, or have you recently taken, drugs that can weaken the immune system like steroids (e.g. prednisone), some medicines for autoimmune disease, or medicines taken after an organ transplant?
4. Are you now taking cancer treatment with drugs or radiation or have you taken such treatment in the past 3 months?

Skin Problems

5. Do you now have, or have you ever had atopic dermatitis, often called eczema (even as a baby or child and even if the condition is mild)?
6. Do you now have other skin problems that have made many breaks in your skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, or severe acne?
7. Do you have Darier's disease (a skin problem that usually begins in childhood)?

Heart Problems

8. Have you ever been diagnosed by a doctor as having a heart condition with or without symptoms such as previous myocardial infarction (heart attack), angina (chest pain caused by lack of blood flow to the heart), congestive heart failure, or cardiomyopathy?
9. Have you ever had a stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)?
10. Do you have chest pain or shortness of breath when you exert yourself (such as when you walk up stairs)?
11. Do you have any other heart condition for which you are under the care of a doctor?
12. Do you have three of more of the following risk factors?
    a. You have been told by a doctor that you have high blood pressure
    b. You have been told by a doctor that you have high blood cholesterol.
    c. You have been told by a doctor that you have diabetes or high blood sugar.
    d. You have a first degree relative (for example mother, father, brother, or sister) who had a heart condition before the age of 50.
    e. You smoke cigarettes now.

Date: _____ (mm dd yyyy)

Patient Name: _____ **PVN:** _____

SECTION E PATIENT MEDICAL HISTORY *continued*

Pregnant or Breastfeeding

13. Are you pregnant, might be pregnant, or might become pregnant in the next month?
14. In the past month, have you had any sex without using effective birth control or do you think you will have sex without using effective birth control during the month after vaccination?
15. Are you currently breastfeeding or pumping and then bottle-feeding breast milk?

Other

16. Have you ever had a life-threatening allergic reaction to smallpox vaccine, latex or the antibiotics polymixin B, streptomycin, chlortetracycline, or neomycin?
17. Are you now being treated with steroid eye drops?

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE,
YOU SHOULD NOT GET THE SMALLPOX VACCINE AT THIS TIME.

If you answered NO, please continue with the following questions about your close contacts.

Do any of the following apply to your CLOSE CONTACTS? ☐ Yes ☐ No

(A close contact is someone you live with or have close physical contact with, such as a sex partner. Close contacts do not include friends or co-workers.)

Weakened Immune System

1. Do any of your close contacts have conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?
2. Do any of your close contacts have a severe autoimmune disease such as lupus that may weaken the immune system?
3. Are any of your close contacts now taking, or have they recently taken, drugs that can weaken the immune system like steroids (e.g. prednisone), some medicines for autoimmune disease, or medicines taken after an organ transplant?
4. Are any of your close contacts taking cancer treatment with drugs or radiation or have they taken such treatment in the past 3 months?

Skin Problems

5. Do any of your close contacts now have, or have they ever had atopic dermatitis, often called eczema (even as a baby or child and even if the condition is mild)?
6. Do any of your close contacts now have other skin problems that have made many breaks in their skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, severe diaper rash, or severe acne?
7. Do any of your close contacts have Darier's disease (a skin problem that usually begins in childhood)?

Pregnancy

8. Are any of your close contacts pregnant, might be pregnant, or might become pregnant in the next month?

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE,
YOU SHOULD NOT GET THE SMALLPOX VACCINE AT THIS TIME.

Screener comments/Notes for clarification (for clinic use only) _____

Date: _____ (mm dd yyyy)

Patient Name: _____ **PVN:** _____

SECTION F SIGNED CONSENT (TO BE KEPT BY THE VACCINATION CLINIC)

I have:

- received, read and understand the Smallpox Pre-Vaccination Information Package, including the Vaccine Information Statement (VIS) and the pre-event screening worksheet;
- considered my own health status as well as the health status of my close contacts;
- had the opportunity to discuss my medical concerns with my health care provider or a health care provider at the vaccination clinic;
- had the opportunity to obtain a referral to seek confidential laboratory testing for medical conditions that may increase my risk for adverse reactions from the vaccine;
- responded to the questions above to the best of my ability.

I understand that getting the vaccine is my choice. I agree to get the smallpox vaccine.

_____ _____

Patient signature Date

Privacy Act Statement

The information requested on this form, including the Social Security Number (SSN), is collected under the authority of Section 311 of the Public Health Service Act (42 U.S.C. 243), the NCVIA (42 U.S.C. 300aa-2(a)), and Section 304 of the Homeland Security Act of 2002 (Pub. L. No. 107-296). The information will be used in the analysis and follow-up of significant events associated with smallpox vaccination and to assure availability of smallpox response teams. The SSN is being collected for identity verification purposes. Furnishing the requested information, including SSN, is voluntary; however, with more complete information, public health objectives, such as adequate monitoring and follow-up of potential adverse events, are more readily achievable. Individuals who do not provide all of the requested information (except items marked as optional) will not be eligible to receive the smallpox vaccine. Identifiable information may be shared by the Centers for Disease Control and Prevention with authorized U.S. Department of Health & Human Services' personnel and public health or cooperating medical authorities.

Date: _____ (mm dd yyyy)

Patient Name: _____ **PVN:** _____

SECTION G CURRENT VACCINATION INFORMATION (CLINIC STAFF WILL FILL OUT THIS SECTION)

Vaccination clinic and vaccine batch information do not need to be filled out if a pre-printed, pre-populated PVS patient medical history and consent form attachment is used.

Vaccination Clinic Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

County: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Disposition

☐ **Referred for Vaccination** ☐ **Deferred for medical reasons** ☐ **Vaccination refused**

† *Was a smallpox vaccination scar seen by clinic staff?* ☐ Yes ☐ No

† Vaccinee status? ☐ Primary vaccinee ☐ Revaccinee

Vaccination Administration Information

Date of Vaccination: _____ (mm dd yyyy) Arm vaccinated: ☐ Left ☐ Right ☐ Other: _____

Vaccine Administered by: _____

Please print first name, last name, and professional suffix (MD, RN, etc.)

Vaccine Batch Information

Vaccine Type:	Batch #:
Program:	External #:
Dilution Strength:	Batch Date:
Diluent Lot #:	Vaccine Lot #:
Diluent Lot Manufacturer:	Vaccine Lot Manufacturer:

Take Evaluation and Response

Name of the organization/clinic where take will be evaluated: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

County: _____ Phone: (_____) _____ - _____

Take response evaluation performed by: _____

Please print first name, last name, and professional suffix (MD, RN, etc.)

Date of Evaluation (should be 6-8 days after vaccination): _____ (mm dd yyyy)

Take Response (check only one box)

☐ **Major** (usually successful vaccination is characterized by a pustular lesion or an area of definite induration or congestion surrounding a central lesion, which might be a scab or an ulcer; go to the CDC website listed below for more information)

☐ **Equivocal** (all other responses)

☐ **Not available**, reason: _____

(e.g., cannot be contacted, died, hospitalized, refused, other)

Is the vaccinee considered immune for response team work?

☐ Yes (the vaccinee had a Major response or was a revaccinee and had two Equivocal responses)

☐ No

Additional comments: _____

† To determine vaccinee's status, see marked *italicized* items in sections A, B, and G. For more information on determining vaccination status or assessing vaccination responses, go to www.bt.cdc.gov/agent/smallpox/vaccination/statusprocedure.asp

Adverse events should be reported to VAERS at www.vaers.org or 1-800-822-7967