Valley Infectious Disease Associates

Medical History and Consent Form

Name: _____ DOB: _____

Primary Care Physician: _____

1. Are these vaccines required for work or school? Y/N

Health Information Are you or have you:

1. Been treated for leukemia, lymphoma, or any other malignant disease? Y/N
   If yes, explain: _____

2. Have a history of condition(s) such as diabetes, heart or lung disease, thymoma, Myasthenia Gravis, immune system, HIV infection, or bleeding disorder? Y/N
   If yes, explain: _____

3. Currently taking any prescribed or over the counter medications? Y/N
   If yes, please list: _____
   _____

4. Allergic to any medications, eggs, gelatin, latex, thimerosol, or vaccines? Y/N
   If yes, explain: _____
   _____

5. Received blood, blood products, or Immune globulin in the past year? Y/N
   If yes, explain: _____

WOMEN ONLY

1. Are you pregnant, or suspect you may be pregnant or trying to become pregnant? Y/N

2. Are you breast-feeding? Y/N

Immunization History-Have you:

1. Received polio vaccine as a child? Y/N
   If no, please explain: _____
2. Had tetanus vaccination in the last 10 years? Y/N
   If yes, when: _____
3. Received other vaccines in the last 4 weeks? Y/N
   If yes, which ones and when: _____

I authorize Valley Infectious Disease Associates to administer the following vaccine(s):

___Varicella (chicken pox)	___Zostavax	___Pneumonia	___Typhoid
___Hepatitis A	___MMR	___Polio	___Yellow Fever
___Hepatitis B	___Meningitis	___Td T-dap__	___Other

I understand I will be given and must read the Vaccine Information Sheet(s) for the vaccines that I will be receiving.

The nature and benefits, the risks and possible side effects of the proposed vaccine(s) have been explained to me and I have been advised of my right to refuse such vaccines and the possible consequences of such decision.

I am aware that the vaccine(s) may not have the desired objectives and the no warranty or guarantee has been made.

Signature: _____ Date: _____
Patient(s) or patient's legal representative and relationship to patient