Travel Clinic　Questionnaire for Immunization

Name of the person who receives vaccination		M　F	Date of birth day / month / year
Parent/Guardian's Name			/ /
Address		TEL	

Please answer the following questions about the person who receives vaccination.

	Questionnaire	Answer		Doctor's comment
1	Current body temperature	℃		
2	Are you sick today ?	Yes → Please describe in detail.	No	
3	Have you been ill in the past month ?	Yes → Disease name	No	
4	Has any family member or friend had measles, rubella, chicken pox or mumps in the past month ?	Yes → Disease name	No	
5	Have you been vaccinated any live vaccine within 4 weeks ?	Measles Rubella Poliomyelitis BCG Mumps Chicken pox Yellow fever	No	
6	Have you been vaccinated any inactivated vaccine within one week ?	Yes → Vaccine name	No	
7	Please check the following vaccine if you have received in the past.	Hepatitis A Hepatitis B Japanese encephalitis Typhoid fever Rabies Tetanus DPT Yellow fever Meningococcal meningitis		
8	Do you have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency or any other diseases for which you have consulted a doctor ?	Yes → Disease name	No	
9	Have you had convulsion in the past ?	Yes → In what age ? How frequently ?	No	
10	Have you had any adverse reaction to a vaccine in the past ?	Yes → Vaccine name	No	
11	Have you ever had urticaria or any other illness as a reaction to medications or foods ?	Yes → Medicine name / Food name / Symptom	No	
12	Have you received a blood transfusion or an injection of gamma globulin in the past 6 months ?	Yes	No	
13	For female only. Are you pregnant ? Or Is there any possibility that you are currently pregnant ?	Pregnant Possibility of current pregnancy	No	
14	Do you have any questions about today's vaccination?	Yes	No	

Doctor's comment: Based on the above answers and results of interview, I have decided that above-mentioned person (can / should not) receive vaccination today. I have explained to above-mentioned person or parent/guardian the information concerning the benefits and side effects of vaccination and the support provided to people who have had adverse events associated with vaccination.

Signature or Name and Seal of Doctor

This screeing questionnaire is used to improve the safety of vaccination. I have been interviewed and examined by the doctor, and information concerning the benefits, objectives and risks (including serious side effects) of vaccination has been explained to me by the doctor, as has the nature of support provided if adverse events occur. I believe that I understand this information. I (do / do not) give consent to this vaccination. (Please circle your choice.)

Signature of the person who receives vaccination or parent/guardian.

Institution : Juko Memorial Nagasaki Hosptal

Name of the attending doctor : KEI MIYAGI　Signature:　Date administered: / / (day/month/year)