Patient Consent Form

US H&P MEDICAL SERVICES, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **US H&P Medical Services, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by **US H&P Medical Services, LLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **US H&P Medical Services, LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19425 484-875-3057.**

With this consent, **US H&P Medical Services, LLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **US H&P Medical Services, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **US H&P Medical Services, LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **US H&P Medical Services, LLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **US H&P Medical Services, LLC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **US H&P Medical Services, LLC** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable

Authorization Form

US H&P MEDICAL SERVICES, LLC

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **US H&P Medical Services, LLC** to use and/or disclose certain protected health information (PHI) about me to __________________________.

This authorization permits **US H&P Medical Services, LLC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **date 12/31/2018.**

The Practice will ____will not ____receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **US H&P Medical Services, LLC** . In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057.

Signed by: ________________________________ ________________________
Signature of Patient or Legal Guardian Relationship to Patient

________________________________ ________________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Notice of Privacy Practices

Effective date: 07/15/09

US H&P MEDICAL SERVICES, LLC

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis.
2. Diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

3. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
4. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
5. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
6. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
7. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
8. Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
9. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,

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• Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
• Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:
• Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
• Concerning a death we believe has resulted from criminal conduct,
• Regarding criminal conduct at our offices,
• In response to a warrant, summons, court order, subpoena or similar legal process,
• To identify/locate a suspect, material witness, fugitive or missing person,
• In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety

of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 1-877-888-4544** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

1. **Inspection and copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **US H&P Medical Services, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to

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2. inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

5. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057**.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **US H&P Medical Services, LLP, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **US H&P Medical Services, LLC, 101 Lindenwood Drive, Suite 225, Malvern, PA 19355, 484-875-3057.**

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Signed by: ______________________________ ______________________

Signature of Patient or Legal Guardian   Relationship to Patient

______________________________ ______________________

Print Patient's Name   Date

____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

1. **SYPHILIS**

    a. Required Evaluation

    All applicants 15 years of age or older must be tested for evidence of syphilis.

    Applicants under the age of 15 years must be tested if there is reason to suspect infection with syphilis.

    b. Tests for Syphilis

    A Venereal Disease Research Laboratory (VDRL) or rapid plasma regain (RPR) or equivalent test may be used for screening. Positive results on screening tests should be confirmed using a fluorescent treponemal antibody absorbed (FTS-ABS), TPHA, or other confirmatory test.

    c. Reporting Results

    The applicant must be treated with a standard treatment regimen (appendix A) and will be referred to your health department or infectious disease specialist for initial treatment and counseling, before the medical report form is completed. The results of the testing and medication, dose, and date of treatment will be written on the medical report form.

    Once the recommended treatment is completed, syphilis is no longer a Class A condition. It is a residual disability (e.g., an individual treated for neurosyphilis who has a residual neurologic abnormality).

2. **GONORRHEA**

    a. Required Evaluation
    All applicants 15 years of age or older must be tested for evidence of gonorrhea.

    Applicants under the age of 15 years must be tested if there is a reason to suspect infection with gonorrhea.

    b. Tests for Gonorrhea
    A nucleic acid amplification test (NAAT) or culture may be used for screening. NAAT allows testing to be performed on specimens such as urine (from men or women).

    c. Reporting Results

    The applicant must be treated with a standard treatment regimen (appendix A) and will be referred to your health department or an infectious disease specialist for initial treatment and counseling, before the medical report form is completed. The results of the testing and medication, dose, and date of treatment will be written on the medical report form.

    Once the recommended treatment is completed, gonorrhea is longer a Class A condition. It is a residual disability.

3. **TUBERCULOSIS (TB) TESTING**

All patients must have a TB blood test to determine TB/tuberculosis. If your TB blood test comes back positive, a chest x-ray will be required to determine active disease.

If your chest x-ray findings are positive for active disease or suggestive of changes, we will notify and refer you to your health department or medical specialist for further treatment and follow up if necessary.

______________________________ ______________________________ ____________
Printed Name Signature Date

USH&P Medical Services, LLC
101 Lindenwood Drive, Suite 225, Malvern, PA 19355
Phone: 484-875-3057
Fax: 484-341-8117

USH&P Medical Services, LLC
101 Lindenwood Drive, Malvern, PA 19355 Phone: 484-875-3057

REGISTRATION FORM

PATIENT NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH / /	AGE	SOCIAL SECURITY NUMBER - -

SEX O M O F	MARITAL STATUS:	❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Life Partner ❑ Widowed ❑ Never Married	RELIGION	CHURCH

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE	CELL PHONE	EMAIL ADDRESS

PLACE OF BIRTH COUNTRY OF BIRTH

PRIMARY CARE PHYSICIAN	PHYSICIAN'S TELEPHONE

ADDRESS	CITY	STATE	ZIP CODE

OCCUPATION	EMPLOYER

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE	

ATTORNEY NAME:	LAW FIRM NAME:

			PHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

EMERGENCY CONTACT **NEXT OF KIN**

NAME	RELATION	NAME	RELATION
TELEPHONE	EMPLOYMENT TELEPHONE	TELEPHONE	EMPLOYMENT TELEPHONE
CELL PHONE		CELL PHONE	

PATIENT IDENTIFICATION (please select one)

PASSPORT	DRIVER'S LICENSE	GREEN CARD

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES - A detail of your rights and how your medical information will be used and disclosed by USH&P Medical Services is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been furnished to me,

I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge.

I authorize the release of medical information to health professionals, credit card companies and/or government agencies indicated for information requested in order to determine the payment of any balance. The information authorized for release may include information about communicable or noncommunicable disease, mental health, and substance or alcohol abuse. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES

SIGNATURE: ______________________ DATE ______________

PATIENT MEDICAL HISTORY

PERSONAL & FAMILY HISTORY

If a member of your family has had one of these conditions, and indicate theirr relationship to you.

DESCRIPTION	PERSONAL		FAMILY		RELATION	DESCRIPTION	PERSON			FAMILY		RELA
	YES	NO	YES	NO				NO		YES	NO	
Hearing problems						Diabetes						
Heart disease / Circulatory problems						Epilepsy or seizures						
High blood pressure						Migraine headaches						
Stroke						Arthritis or Gout						
Asthma, emphysema, bronchitis						Depression/ Nervous problem						
Ulcers/Digestive problems						Hepatitis or liver problems						
Drug / Alcohol problems						Thyroid disease						
Cancer: Breast						Anemia / Blood diseases						
Colon						Tuberculosis						
Prostate						Osteoporosis						
Other (please specify)						STDs: Herpes						
High cholesterol						Gonorrhea						
Kidney stones / Cysts / Failure						Syphilis						
Gallbladder						Other (please specify)						
Other (please specify)						Auto-Immune Disorders: (HIV/AIDS)						

SOCIAL HISTORY

Please indicate your usage of the following:

Tobacco ❑ No ❑ Yes	PACKS/CANS PER DAY: # OF YEARS:		Date Quit:
Alcoholic Beverages ❑ No ❑ Yes	HOW MANY DRINKS PER WEEK:		
Caffeinated Beverages ❑ No ❑ Yes	HOW MANY CUPS PER DAY:		
Recreational Drugs ❑ No ❑ Yes	USAGE PER WEEK:		
# of Children at Home: # of Pregnancies:	# OF MISCARRIAGES/ LOST PREGNANCIES:	ANY COMPLICATIONS:	
Date of Last Menstrual Period:			

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TESTS

Hospitalization/Surgery/Diagnostic Test	Date	Hospitalization/Surgery/Diagnostic Test	Date

MEDICATIONS & PRESCRIPTIONS

Please list any prescription or over-the-counter medications (with doses) you are currently taking:

Medication Name & Dose	Medication Name & Dose	Medication Name & Dose

ARE YOU ALLERGIC TO ANY MEDICATIONS? : ❑ No ❑ Yes (please specify) ____________________

Do you have any allergies to latex, IV dye or anything else that should be noted? ❑ No ❑ Yes (please specify)

____

IMMUNIZATIONS

Type of Immunization	Date of Last Immunization	Other Immunizations	Date
Pneumonia			
Tetanus			
Influenza			
TB Skin Test			
Measles, Mumps, Rubella (MMR)			

REVIEW OF SYMPTOMS

Do you have any of the following?	**Yes**	**No**	**Do you have any of the following?**	**Yes**	**No**
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision / Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea/constipation		
Difficulty hearing			Irregular periods		
Seasonal allergies			Frequent urinary tract infections		
Sinus problems			Kidney stones		
Shortness of breath with or without exertion			Back pain		
Wheezing			Joint pain or swelling		
Cough			A history of broken bones		
Skin problems (rash, eczema, psoriasis)			Swelling of the legs		
Other (Please specify)					

OTHER

Do you wear corrective lenses? _____Yes ____No

Do you have any implanted medical devices? ____Yes _____No

Patient Name: ______________________
Birth date: ______________________
ID Number: ______________________

VACCINE INFORMATION SHEET

GENERAL QUESTIONS:

	YES	NO	COMMENTS
ARE YOU SICK TODAY?			
ARE YOU PREGNANT?			
DO YOU HAVE, OR ARE BEING TREATED FOR ACTIVE TUBERCULOSIS?			
HAVE YOU RECEIVED ANY VACCINATION IN THE PAST 4 WEEKS?			
HAVE YOU RECEIVED BLOOD PLASMA IN THE PAST 3 WEEKS?			
DURING THE PAST YEAR, HAVE YOU RECEIVED A TRANSFUSION OF BLOOD OR BLOOD PRODUCTS, OR BEEN GIVEN IMMUNE (GAMMA) GLOBULIN OR AN ANTIVIRAL DRUG?			
DO YOU TAKE CORTISONE, PREDNISONE, OTHER STEROIDS, OR ANTICANCER DRUGS, OR HAVE YOU HAD RADIATION TREATMENTS?			

HAVE YOU HAD ANY OF THE FOLLOWING REACTIONS TO PAST VACCINATIONS:

	YES	NO	VACCINATION
ANAPHYLAXIS			
GUILLAIN BARRE SYNDROME			
EPILEPSY			
CONVULSIONS			
ENCEPHALITIS			
NEUROLOGICAL SYMPTOMS			
ANY OTHER SERIOUS REACTION AFTER A VACCINATION?			

DO YOU HAVE ALLERGIES TO THE FOLLOWING FOODS OR MEDICATIONS:

	YES	NO	COMMENTS
NEOMYCIN			
STREPTOMYCIN			
POLYMYXINB			
GENTAMYCIN			
EGGS			
GELATIN			
BAKER'S YEAST			
OTHER			

DO YOU HAVE THE FOLLOWING DISEASES/CONDITIONS:

	YES	NO	COMMENTS
MODERATE TO SEVERE ILLNESS (COLD)			
CANCER			
UNDER CHEMOTHERAPY FOR CANCER			
RADIATION FOR CANCER			
AIDS			
IMMUNOLOGICAL DISORDERS			
TAKING IMMUNE DRUGS			
BLOOD DISCORDS			
STEROID THERAPY			
RECENT IG, VZIG INJECTION			
SEIZURE, BRAIN, OR OTHER NERVOUS SYSTEM PROBLEMS?			
LONG TERM HEALTH PROBLEMS: HEART DISEASE, LUNG DISEASE, ASTHMA, KIDNEY DISEASE, METABOLIC DISEASE (E.G., DIABETES), ANEMIA, OR OTHER BLOOD DISORDERS?			

Address

Telephone Number

Must Be Filled Out By Patient

Vaccine Administration Record for Adults

Have you received vaccines for the following diseases?

				If Yes, please fill out:		
Vaccines	Unknown	No	Yes	Date Given (MM/DD/YY)	Location/Country	Vaccinating Doctor
Measles, Mumps, Rubella, MMRY (MMR) Give SC.						
Polio OPV IPV						
Tetanus, Diphtheria, Pertussis (E.g., Td, Tdap) Give IM DT Td Dtap Tdap						
Haemophillas Influenza B (Hib)						
Hepatitis B						
Varicella (Chicken Pox) History – Yes/No						
Hepatitis A						
Meningococcal						
Human Papilloma Virus (HPV)						
Zoster/Herpes						
Rotavirus						
Influenza						
Tuberculosis						

Address

Telephone Number