

SMALLPOX VACCINATION PRE-SCREENING FORM

Name: _____

Date: _____

Social Security Number: _____

Gender: Male ___ Female ___

- | | |
|---|---------------------------|
| 1. Females: Was your last menstrual period normal and on time? * | Yes ___ No ___ |
| Are you currently breastfeeding? | Yes ___ No ___ |
| 2. Could someone you LIVE WITH or YOU be pregnant? | Yes ___ No ___ Unsure ___ |
| 3. Did you ever receive smallpox vaccine? | Yes ___ No ___ Unsure ___ |
| IF UNSURE: Birth Year: _____ First Year in Military (if applicable): _____ | |
| 4. Have you ever had a serious problem after smallpox or other vaccinations? (Describe below) | Yes ___ No ___ Unsure ___ |
| 5. Are you allergic to any of these products: Tetracycline, Streptomycin, Polymyxin B, Neomycin, latex? | Yes ___ No ___ Unsure ___ |

Before vaccinating against smallpox, we want to know if you or your household close contacts have any of several medical conditions. Please answer the following questions to the best of your knowledge.

"Close Contact" means a person who you live with. It also means a person you have close physical contact with, such as a sex partner or someone you share bed with. Friends or people you work with are not "close contacts."

- | | Myself | Close Contact |
|---|------------------------------|------------------------------|
| 6. Do you or someone you currently live with NOW HAVE any of the following skin problems: psoriasis (scaly skin rash), burns (other than mild sunburn), impetigo (skin infection), uncontrolled acne, shingles (herpes zoster), chickenpox, Darier's disease (a rare genetic chronic skin disorder), or other skin condition with multiple breaks in skin? | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 7. Do you or someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For Example:
-have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem
-have or take medication for Crohn's disease, lupus, arthritis, or other immune disease
-have had radiation or x-ray treatment (not routine x-rays) within the last 3 months
-have EVER had a bone-marrow or organ transplant (or take medication for that)
-have another problem that requires steroids, prednisone, or a cancer drug for treatment | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8. Have you or someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) IF YES or UNSURE: for either you or your close contact, answer 8a-8e. | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8a. A doctor has made the diagnosis of eczema or atopic dermatitis. | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8b. There have been itchy rashes that have lasted more than 2 weeks. | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8c. At least once, there is a history of an itchy rash in the folds of the arms or legs. | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8d. There is a history of eczema and food allergy during childhood. | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 8e. A doctor has made the diagnosis of asthma or hayfever (including first degree relatives). | Yes ___ No ___
Unsure ___ | Yes ___ No ___
Unsure ___ |
| 9. Do you have other questions or have other concerns you would like to discuss? | Yes ___ No ___ | |

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10. CARDIAC PRE-SCREEN: Please complete the following to the best of your ability.

Conditions	Do you have this condition?	
	(Circle)	
A previous heart attack (also called myocardial infarction)	YES	NO
Angina Pectoris (chest pain caused by lack of blood flow to the heart)	YES	NO
Other coronary artery disease (disease in the vessels that bring blood to the heart)	YES	NO
Cardiomyopathy (heart muscle becomes inflamed and doesn't work as it should)	YES	NO
Congestive Heart Failure	YES	NO
Chest pain or shortness of breath with activity (such as climbing stairs)	YES	NO
Stroke of transient ischemic attack (a "mini-stroke" or TIA that produces Stroke-like but no lasting damage)	YES	NO
Other heart conditions under the care of a doctor	YES	NO

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU SHOULD NOT RECEIVE THE SMALLPOX VACCINE AT THIS TIME WHILE EXPERTS CONTINUE THEIR INVESTIGATIONS INTO THESE CONCERNS.

Risk Factor	Have you been told by a doctor that you have this condition?	
	YES	NO
High blood pressure	YES	NO
High blood cholesterol	YES	NO
Diabetes or high blood sugar	YES	NO
Have a 1 st degree relative (such as a mother, father, sister, or brother) who had a heart condition before the age of 50	YES	NO
Smoke cigarettes now	YES	NO

IF YOU ANSWERED "YES" TO 3 OR MORE OF THE ABOVE QUESTIONS ABOUT RISK FACTORS, YOU SHOULD NOT GET THE SMALLPOX VACCINE AT THIS TIME.

NOTE: If you think you might have one of the many risk factors for HIV infection, we can assist you with arranging for HIV testing prior to vaccination.
 *FOR FEMALES: If you think you might be pregnant, you should have a pregnancy test prior to vaccination.

Explain "other", "unsure", or additional concerns : _____

EMPLOYEE SIGNATURE: _____

DATE: _____

REVIEWING PHYSICIAN: _____

DATE: _____