

# Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name \_\_\_\_\_

Age \_\_\_\_\_

	Yes	No	Don't know
<b>1.</b> Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2.</b> Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>If yes, which vaccine product did you receive?                              <input type="checkbox"/> Pfizer-BioNTech    <input type="checkbox"/> Moderna    <input type="checkbox"/> Janssen (Johnson &amp; Johnson)    <input type="checkbox"/> Another Product _____                         </li> <li>Have you received a complete COVID-19 vaccine series (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])?                              <input type="checkbox"/> Yes    <input type="checkbox"/> No                         </li> <li>Did you bring your vaccination record card or other documentation?                              <input type="checkbox"/> Yes    <input type="checkbox"/> No                         </li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b> Have you ever had an allergic reaction to:			
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> <li>A component of a COVID-19 vaccine, including either of the following:                             <ul style="list-style-type: none"> <li>Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures                                      <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know                                 </li> <li>Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids                                      <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know                                 </li> </ul> </li> <li>A previous dose of COVID-19 vaccine                              <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know                         </li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4.</b> Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<b>5.</b> Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_