Patient History & Vaccine Administration Record

Patient Name: _____
Community:_____Resident/employee
Address: _____
Date of Birth:_____/_____/_____
Phone Number_____
SS#_____
Primary Care Provider: _____
Email:_____
Medicare Yes / No. Medicare ID #_____
Non Medicare Pharmacy Benefit Plan_____ ID#_____ Grp#_____

PCN:_____ BIN:_____Phone:_____

Please circle your answers to the questions below.

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications or foods?	Yes	No
3.	Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (ie: diabetes), anemia, or other blood disorder?	Yes	No
5.	Do you have cancer, leukemia, HIV/AIDS, or any other issue with your immune system?	Yes	No
6.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
7.	Have you had a seizure, brain disorder or other nervous system problem?	Yes	No
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
9.	Have you received any vaccinations in the past 4 weeks?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No

I have read or have had read to me the information regarding the vaccine(s) I am receiving today. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits & risks of the vaccine(s). I have given consent for the administration of the vaccine(s) marked below.

Printed Name:_____

Signature:_____ Date_____/____/2025____

—For Office Use Only—

Covid	Fluad 65+	Pneumonia	RSV	Shingles	Flu under 65	Other
Lot# 8146545 EXP: 05/12/26 Moderna	Lot# 407261 EXP: 5/2/26 SEQIRUS	Lot# EXP: Pfizer	Lot# EXP: Moderna	Lot# Exp: GSK	Lot# Exp: Seqirus	Lot# Exp:

Date of Vaccination: / /2025 Site of vaccination: Left or Right Deltoid

Vaccine administered by:_____Signature:_____

Entered into SHOTS by:_____ Date:_____/_____/2025_____