Vaccination Questionnaire

年　月　日

Name	Patient ID
Address	Phone number
Date of birth / / (Day/Month/Year) years	Body temperature ℃

Please circle below the vaccines you are requesting

Hepatitis A / Hepatitis B / DT / DPT /DPT-IPV/Tetanus / Polio / Diphtheria / Hib / BCG / PCV13 / Japanese Encephalitis / MR / Measles / Rubella / Mumps / Varicella(Chicken Pox) / PCV23 / Shingles / Meningococcus / Rotavirus / Influenza / Rabies/Typhoid/Cholera/HPV(Gardasil)/HPV(Silgard9)

Please answer "Yes" or "No" to the following questions

1. Do you feel unwell today? Symptoms ( )	Yes	No
2. Do you currently have any medical problems? What is it? ( )	Yes	No
3. Do you currently take any medications? Name of medication ( )	Yes	No
4. Have you ever had any medical problems?	Yes	No
5. Have you ever had convulsions? If so, when did you have it? ( )	Yes	No
6. Have you ever had an allergic reaction after receiving medicine or eating specific foods?	Yes	No
7. Have you ever had an allergic reaction to eggs?	Yes	No
8. Have you been diagnosed with immunodeficiency?	Yes	No
9. Have you received any immunization within the last 4 weeks? Name of vaccination ( ) When ( )	Yes	No
10. Have you ever felt sick after receiving an immunization? Name of vaccines and symptoms ( )	Yes	No
11. Have you ever felt sick with blood draw or dental treatment?	Yes	No
12.《Women only》Is there a possibility you are pregnant?	Yes	No
13. Do you have any concerns about your health?	Yes	No

I understand the effect, purpose and risks associated with vaccination. I voluntarily agree to receive vaccination(s).

(Yes / No)

Signaure

Signature of patient/guardian　　Date / / (Day/Month/Year)

＜Doctor＞According to the result, today's vaccination is　　Possible / Postponed

niseko international clinic
Physician's Signature

＜Nurse＞

Vaccination	LOT.No	Dosage/Route of administration	Site of administration