



113 Harding Way East  
Galion, Ohio 44833

Phone 419.468.1075  
Fax 419.468.8618  
www.galionhealth.org

## Patient Health & Immunization History

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Your Relationship to Patient: \_\_\_\_\_

Has the patient previously received vaccinations at the Galion City Health Department?  No  Yes

### Insurance Status (List **ALL** current policies):

I have Medicaid. Carrier: \_\_\_\_\_ Billing #/ID #: \_\_\_\_\_

I have private insurance. Carrier: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ Billing #/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address (if different from patient): \_\_\_\_\_

Insured's Phone (if different from patient): \_\_\_\_\_ Does this insurance cover shots?  Yes  No

I don't have health insurance.

1. Does the patient have allergies or has he/she had an adverse reaction to medications, vaccines, food, or latex?  No  Yes, please explain: \_\_\_\_\_
2. Is the patient taking any medication at this time?  No  Yes, please explain: \_\_\_\_\_
3. Is the patient sick today or had a fever in the last 24 hours?  No  Yes, please explain: \_\_\_\_\_
4. Is the patient diagnosed with chronic illnesses like lung, heart, or kidney problems, diabetes, asthma, or blood disorders?  No  Yes, please explain: \_\_\_\_\_
5. Has the patient ever had a seizure or has the patient had brain or other nervous system problems?  No  Yes, please explain: \_\_\_\_\_
6. Does the patient have cancer, leukemia, AIDS, or any other immune system problem?  No  Yes
7. Has the patient taken steroids such as prednisone or anticancer drugs including radiation within the last 3 months?  No  Yes
8. Has the patient received blood, blood products, or Gamma Globulin in the past 6 months?  No  Yes
9. Has the patient ever had chickenpox?  No  Yes Has the patient ever received the chickenpox vaccine?  No  Yes
10. Has the patient received any vaccinations in the past 4 weeks?  No  Yes
11. Has the patient received vaccines elsewhere since their last visit here?  No  Yes, where: \_\_\_\_\_
12. For **female** patients: Is there any chance of pregnancy or chance she may become pregnant in the next month?  No  Yes

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines. I grant permission for vaccines that are due to be given today. I grant permission for the patient's immunization record to be released to medical providers, health departments and schools to transmit the immunization history.

If applicable, I authorize payment of medical benefits to the Galion City Health Department for services administered.

I further understand that I am responsible for any co-pays, co-insurance, and/or deductibles required by my insurance carrier.

Will you be returning for additional vaccines?  No  Yes

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Health Department Use Only:**  Public/VFC  Private Return Appointment Needed?  Yes  No

DTap  Varicella  Pneumococcal  Meningitis  Kinrix (DTP, IPV)  Pediarix (DTP, Hep B, IPV)

IPV  MMR  Hepatitis B  HPV  Pentacel (DTP, IPV, HIB)  ProQuad (MMR, Varicella)

HIB  Rotavirus  Tdap/Td  Hepatitis A  Other: \_\_\_\_\_