# Vaccination Questionnaire

Date

**Name** **Hospital ID**

**Date of birth** / / (Day / Month / Year) **Body Temperature** ℃

**【Questions】**

| | | |
|---|---|---|
| 1 | Do you have any concerns about your health today? | Yes ・ No |
| 2 | Do you currently have any sickness? | Yes ・ No |
| | (Name of disease: ) | |
| 3 | Do you currently take any medications? | Yes ・ No |
| | (Name of medicine: ) | |
| 4 | Have you ever had convulsions? | Yes ・ No |
| | If yes, when did you have it? ( ) | |
| 5 | Have you been diagnosed with immunodeficiency? | Yes ・ No |
| 6 | Have you ever had an allergic reaction after receiving medicine or eating a particular food? | Yes ・ No |
| 7 | Have you ever had any allergic reaction after eating eggs? | Yes ・ No |
| 8 | Have you received immunizations within 4 weeks? | Yes ・ No |
| | (When: ) (Name of vaccine: ) | |
| 9 | Have you ever had any sickness in the past? | Yes ・ No |
| | (Name of disease: ) | |
| 10 | Have you ever felt sick after receiving immunizations? | Yes ・ No |
| | If yes, please discribe the scpecific name vaccines and symptoms. ( ) | |
| 11 | Have you ever felt sick with blood sampring or dental treatment? | Yes ・ No |
| 12 | 【Women only】Is there a possibility you are pregnant? | Yes ・ No |
| 13 | Are you a student? (We offer student discount prices for some vaccinations) | Yes ・ No |
| | (Name of school: ) | |
| | Please present your student card to your doctor. | |

**【医師記載】** 以上の問診と診察の結果、本日のワクチンの接種は　可　・　不可

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前回ワクチン接種　　年　　月　　日
HAV( ) HAVhav( )/HBV( )/TT( )/JE( )/Rb( ) Rbv( )/DPT( )/MR( )/HPV( )/Men( )/Ty( )